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MENTAL HYGIENE

VOL. II JULY, 1918 No. 3

CARE AND DISPOSITION OF THE MILITARY INSANE*

PEARCE BAILEY,
Colonel, Medical Corps, N. A.

IMMEDIATELY upon the declaration of war it devolved upon the medical department of the Army to reconsider the existing provisions for the military insane. It was evident that the facilities for the care and treatment, and the regulations controlling disposition, which had sufficed for a small Army, would not meet the enormously enlarged program. All over the United States, to say nothing of France, beds would have to be made ready. Means would have to be devised for the prompt evacuation of these troublesome cases from the active medical services; and, as a man once insane cannot be counted a reliable soldier for general service, all unnecessary delays in the matter of discharge must be obviated. Finally, any system would not be satisfactory which did not cut down transportation to a minimum. The problem was approached in the following ways:

1. Elimination at the source.
2. Care and treatment in military hospitals.
3. Care and treatment in civil hospitals.
4. Evacuation: Army regulations.

1. ELIMINATION AT THE SOURCE

The systematic examinations for the detection of the existence of nervous and mental disease and defect, established in the first place with the object of eliminating from the fighting forces unstable and unreliable individuals, resulted, as will be shown later in this article, in a much smaller number of insane requiring hospital care than had been originally expected.

* Publication approved by the Surgeon General, United States Army.

From the beginning of the mobilization these examinations were carried on at Officers Training Camps, Cantonments, Recruit Depot Posts, and in fact at all points where registrants or volunteers were being mustered into service. By October, 1917, there were approximately 200 officers engaged in this work, mostly Medical Reserve Corps Officers and mostly of considerable civil experience in neurology and psychiatry.

Two chief methods of examination were employed—that of general surveys and that of referred cases.

By the first method, the whole command passes in groups before the special officers, and, on the basis of a brief conversation, observation and examination for tremors, changed reflexes, etc., an estimate is formed as to whether or not further investigation is desirable. An examiner can handle from 100 to 150 men a day in this way without difficulty; and during rush times must handle more.

By the method of referred cases the general survey is omitted and only such cases as are referred by regimental surgeons, company commanders, etc., are examined. This latter method is only reliable when the training period is reasonably long, so that idiosyncrasies, defects, etc., have time to come to the surface under the stress of service.

Co-operation with the psychologists commissioned in the Sanitary Corps, while considered highly desirable and now being carried out, was not possible during the early days of the mobilization, and results obtained by them are not referred to in this article.

Cases recommended for rejection or discharge as a result of these examinations are referred to the surgeon or to a disability board. It has never been considered advisable to recommend that disability boards be composed exclusively of psychiatrists. Composed as they have been of general medical officers, these latter have acquired a better appreciation of the methods and significance of neuropsychiatry and the resulting discharges have not been considered as due to the enthusiasm of "specialists." A large proportion of the recommendations made by neuro-psychiatrists have been approved by the disability boards and later by the commanding officers.

Disqualifications based solely on the existence of nervous or mental disease or defect have been found in from one and one-half to five per cent, varying with the organization examined. It is believed that most of them would not have been recognized by

general medical officers, as they often existed in men physically robust. In many instances also, notably of psychoses and epilepsy, a skillfully elicited and well confirmed history would establish a disability which was not demonstrable or even at first denied at the time of the examination.

Nearly three fourths of the recommendations for discharge made by the neuro-psychiatric examiners were for conditions primarily mental, as opposed to organic disease or defect of the nervous system.

Among the first 13,481 recommendations there were

Mental Defect	4,737 cases, or	35.1%
Epilepsy	1,729 cases, or	12.8%
Psychoneuroses	1,542 cases, or	11.4%
Constitutional Psychopathic State	1,239 cases, or	9.2%
Dementia Praecox	800 cases, or	5.9%
Alcoholism	759 cases, or	5.6%
Manic Depressive	257 cases, or	1.9%
General Paresis	237 cases, or	1.8%

It will be observed that of this large group of recommendations for discharge, 83.7 per cent represented a class of case which is apt at some time or other to require custodial care; and that the elimination at the source of soldiers afflicted with any of the foregoing conditions is an essential part of the program of the care of the military insane, to say nothing of its help in the forming of a strong army.

2. CARE AND TREATMENT IN MILITARY HOSPITALS

All cantonments were provided with neuro-psychiatric hospital units, which consisted of one or two buildings especially designed and equipped to care for nervous and mental patients. The plan included wards and private rooms for officers, day rooms, detention rooms, diet kitchen, etc. The special equipment, not supplied at all stations, consisted of continuous baths, sprays with control tables and different electro-therapeutic apparatus. The commissioned personnel for these wards was designated by the Surgeon General's Office, Division of Neurology and Psychiatry, and the enlisted personnel was made up, as far as possible, from former attendants in state hospitals. Many of these latter were inducted into the service for this purpose.

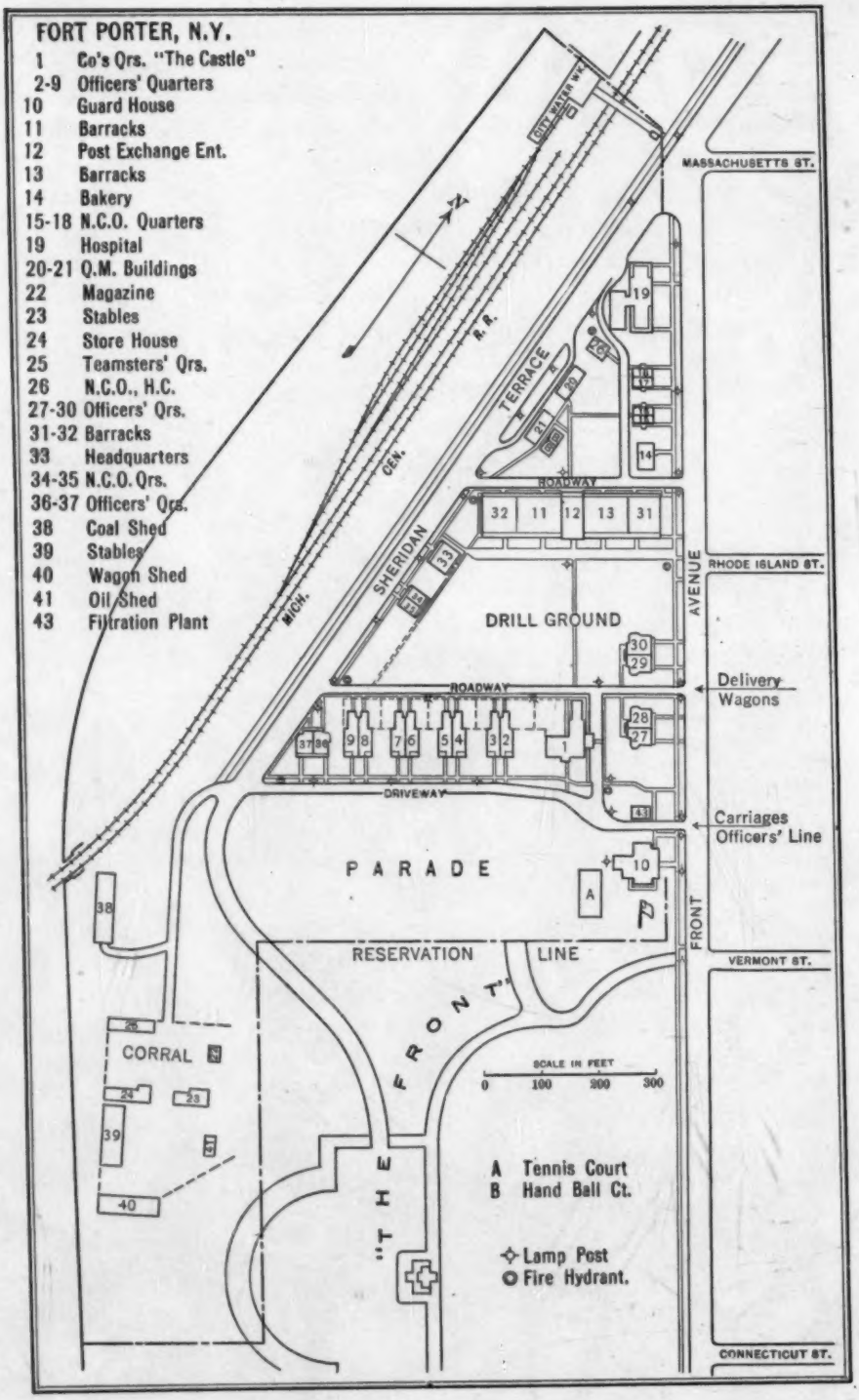
However, the above accomodations did not meet the needs of the situation, either as to the numbers of patients or as to the

general plan. Delays incidental to transfer and discharge caused the beds to be occupied too long by patients who were awaiting discharge, to the exclusion of the actually ill. It was also difficult to maintain an adequate personnel with the requisite experience at so many small units. It was therefore decided to consider these units as places of reception and brief detention only, where patients would remain long enough to receive orders for transfer for treatment elsewhere or to be discharged from the Army.

So it soon became evident that larger and more permanent mental establishments, still of the military service, would have to be provided. These were intended to subserve the functions of psychopathic hospitals in every sense of that term; that is, they were to receive and treat for periods of time, varying from few weeks to a few months, all cases of acute psychoses occurring in both officers and enlisted men. The Letterman General Hospital in San Francisco, being on the return route from the Philippines, had always had special provision of this kind. It was merely decided to enlarge this principle and to put into operation special wards which would be on the return route from the camps. The location most desirable for them was evidently in the centers of dense military population, and this was arranged as nearly as was compatible with the economical utilization of existing facilities. In addition to the wards at Letterman Hospital, there have been established the following *Centers* for the care and treatment of the insane at:

Fort Sam Houston, San Antonio, Texas.
Fort McPherson, General Hospital No. 6, Atlanta, Ga.
Fort Des Moines, Des Moines, Iowa.
Walter Reed General Hospital, Washington, D. C.
Fort Porter, General Hospital No. 4, Buffalo, N. Y.

The first four of these are all of the same type of construction, namely R. 1 and R. 2 buildings of the cantonment plan. In these two buildings are the electric and hydro-therapeutic equipment, single rooms, day rooms, wards for disturbed patients, etc. When necessary the accommodations may be easily increased by the addition of buildings of the ordinary hospital type. For example, there are with capacity of about 100 patients, four buildings in all at Fort McPherson and at Walter Reed Hospital. Fort Sam Houston is not yet in full operation, although it probably


FORT PORTER, N.Y.
1 Co's Qrs. "The Castle"
2-9 Officers' Quarters
10 Guard House
11 Barracks
12 Post Exchange Ent.
13 Barracks
14 Bakery
15-18 N.C.O. Quarters
19 Hospital
20-21 Q.M. Buildings
22 Magazine
23 Stables
24 Store House
25 Teamsters' Qrs.
26 N.C.O., H.C.
27-30 Officers' Qrs.
31-32 Barracks
33 Headquarters
34-35 N.C.O. Qrs.
36-37 Officers' Qrs.
38 Coal Shed
39 Stables
40 Wagon Shed
41 Oil Shed
43 Filtration Plant
MASSACHUSETTS ST.
CITY WATER WKS.
N
R. R.
CEN.
MICH.
TERRACE
ROADWAY
SHERIDAN
AVENUE
RHODE ISLAND ST.
DRILL GROUND
Delivery Wagons
ROADWAY
DRIVEWAY
Carriages Officers' Line
PARADE
FRONT
RESERVATION LINE
VERMONT ST.
CORRAL
THE FRONT
SCALE IN FEET
0 100 200 300
A Tennis Court
B Hand Ball Ct.
Lamp Post
Fire Hydrant.
CONNECTICUT ST.

will be before this article is published. The hospitals at Fort Sam Houston and Fort Des Moines are under the jurisdiction of the Southern and Central Departments respectively, but the others are general hospitals, and so are under the exclusive authority of the Surgeon General.

The former Army Post at Fort Porter is now General Hospital No. 4. The post buildings have been converted at moderate expense to accommodate 155 patients. It is the only Army hospital so far set aside for the exclusive use of the insane. It was primarily intended for expeditionary cases only, but home service cases are constantly being sent there. It is contemplated to establish another set of nervous and mental wards for expeditionary cases nearer the port. This seems advisable both for the purpose of having a greater margin of available beds in case of emergency, and also because many returned cases can thus be given directly into the care of their friends at the port of debarkation, and will be spared the unnecessary journey to Buffalo.

For the Letterman General Hospital, San Francisco, which for years has received the mental cases returned from the Philippines —it is to be remembered that troops serving in foreign countries even in peace times, have a markedly higher insanity rate than troops serving at home—and for the whole Western Department, there is now under construction an additional permanent building to be used as psychopathic wards with a capacity of 50 beds.

The commissioned personnel for these special wards and centers has been selected from Reserve Corps Officers, who have had wide clinical and administrative experience in state or other hospitals for the insane. Most of the enlisted personnel were, before the war, state hospital attendants. Some of these were inducted into the service for the purpose of entering the Medical Corps, with assignment to this special variety of nursing, and others were transferred from other services into the medical service. The National Committee for Mental Hygiene has been of great service in sending to the Surgeon General the names of these experienced attendants. In many of the wards, the head nurse is a trained woman nurse, with special experience, and a member of the Army Nurse Corps.

The sites of the various centers were selected from their being as nearly as possible central points in areas of dense military population. The transfers naturally are from the point where the

soldier was, to the nearest center where beds are available. In general it works out something as follows:

Letterman General Hospital:

Will receive patients from the Philippines and from the Pacific coast generally, e.g., from Camps Kearney, Fremont and Lewis; from General Hospital 20, from Fort Douglas, Utah, etc.

Fort Sam Houston:

Will receive patients from the Southern Department generally, e.g., from Camps Cody, Doniphan, Bowie, MacArthur, Travis, Logan, Beauregard, from Forts Bliss, Sill, Worth, Bayard, etc.

Fort McPherson:

Will receive patients from Camps McClellan, Sheridan, Shelby, Wheeler, Gordon, Hancock, Jackson, Wadsworth, Sevier, Greene; from General Hospitals Nos. 14, 18, 19, etc.

Fort Des Moines:

Will receive patients from Camps Funston, Dodge and Grant; from Jefferson Barracks; from Forts D. A. Russell, Riley, Leavenworth, Snelling, etc.

Port Porter:

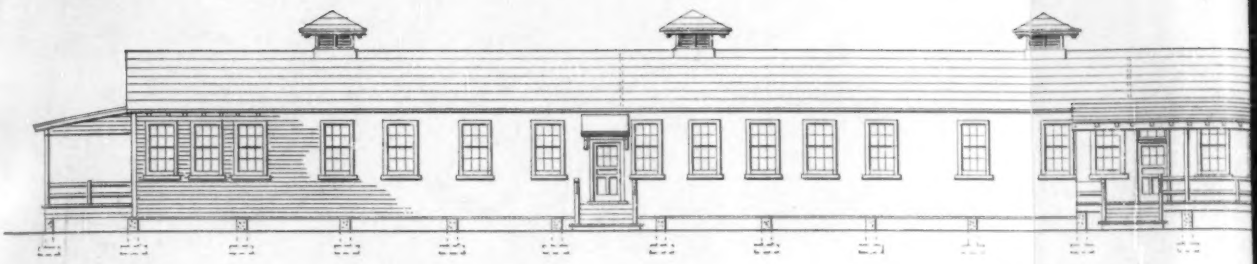
Will receive patients from, in addition to those from all points included in the port of embarkation, General Hospitals Nos. 1, 5 and 16; from Camps Custer, Devens and Upton, and from other posts in the neighborhood.

Walter Reed General Hospital:

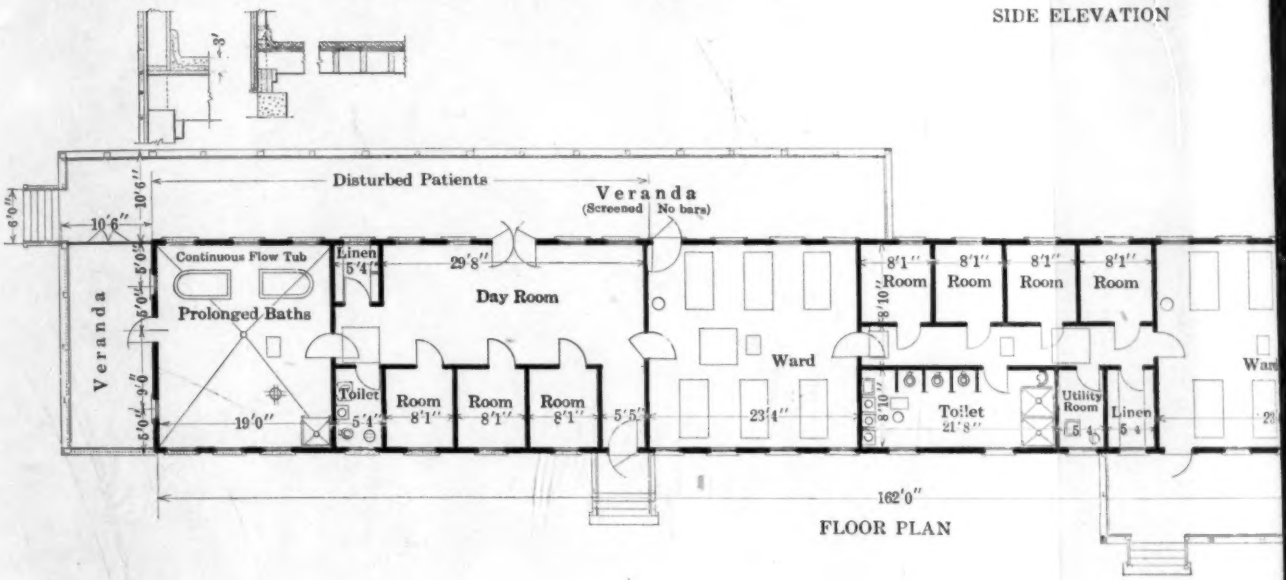
Will receive patients from Camps Dix, Meade, Lee, A. A. Humphreys, Sherman, Taylor; from Washington and Columbus Barracks; from General Hospitals Nos. 2, 3, 7 and 11.

The transfer to the special psychiatric center is effected as follows: The patient whose symptoms are considered as requiring special observation and treatment is ordered for that purpose to the hospital designated. The orders are obtained from the Adjutant General through the Surgeon General, and initiated by the commanding officer at the point from which the patient is removed. Thus the soldier, be he officer or private, presenting the symptoms of insanity, is transferred not as an insane person, but as any other patient. In this way, the Army regulations concerning the disposition of the insane are not resorted to until a reasonable period of observation has elapsed, and if the patient recovers quickly as so many of them do, they need not be resorted to at all. In this latter event, the patient and his friends have the satisfaction of knowing that he has not been sent to any but a military hospital and has not been officially declared as insane.

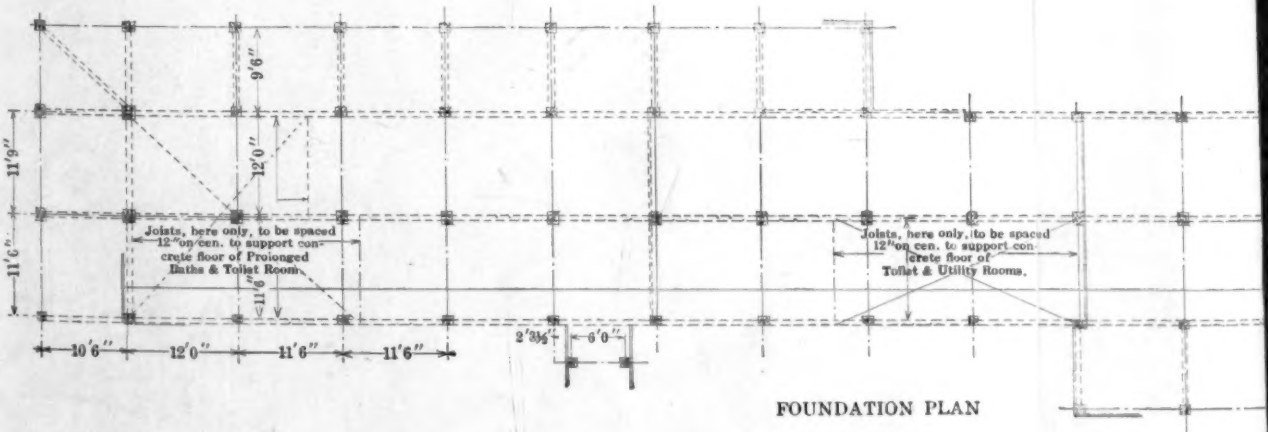
By relieving cantonment and other base hospitals of mental cases in this manner, the congestion of the general medical services has been lessened and a very much higher standard of care, with proportionate increase in speed of recovery, has been obtained. There has also been effected an economy of personnel,



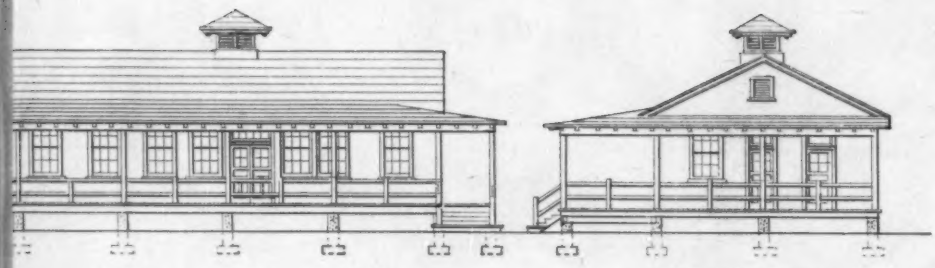
SIDE ELEVATION



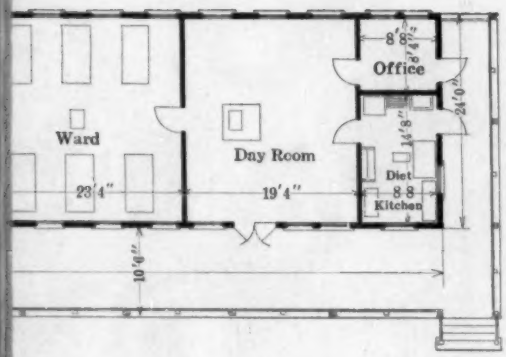
FLOOR PLAN

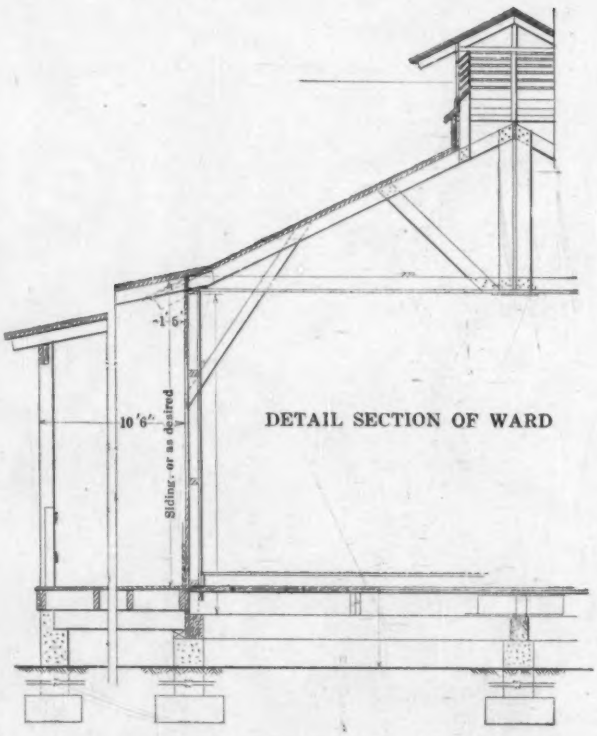


FOUNDATION PLAN

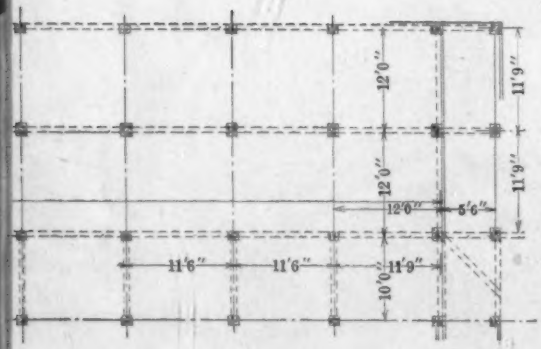


END ELEVATION





DETAIL SECTION OF WARD



NEURO-PSYCHIATRIC WARD

BASE HOSPITAL

UNITED STATES ARMY

for even if it had been possible to supply base hospitals generally with sufficient number of psychiatrists to treat mental cases, it would have been extravagant in the extreme. With the speedy evacuation of all cases presenting mental symptoms, it is now possible for the nervous and mental work in a cantonment base hospital to be performed by one energetic and competent medical officer. As things have turned out this arrangement was imperative, for the need of neuro-psychiatrists at other points in the medical service does not permit, with the present number of these officers available, more than one at a cantonment base hospital.

The efficiency of these centers has been gratifying. Extensive arrangements are being made for occupation, especially gardening. The recovery rate is high and the course of illness brief. For example, the average stay in hospital at Fort Porter is six weeks, at the end of which time the patients are cured or returned to their friends. Few cases have been transferred to permanent custodial institutions. The practical result is that this hospital, with a capacity of 150 beds can provide for 1,200 patients a year.

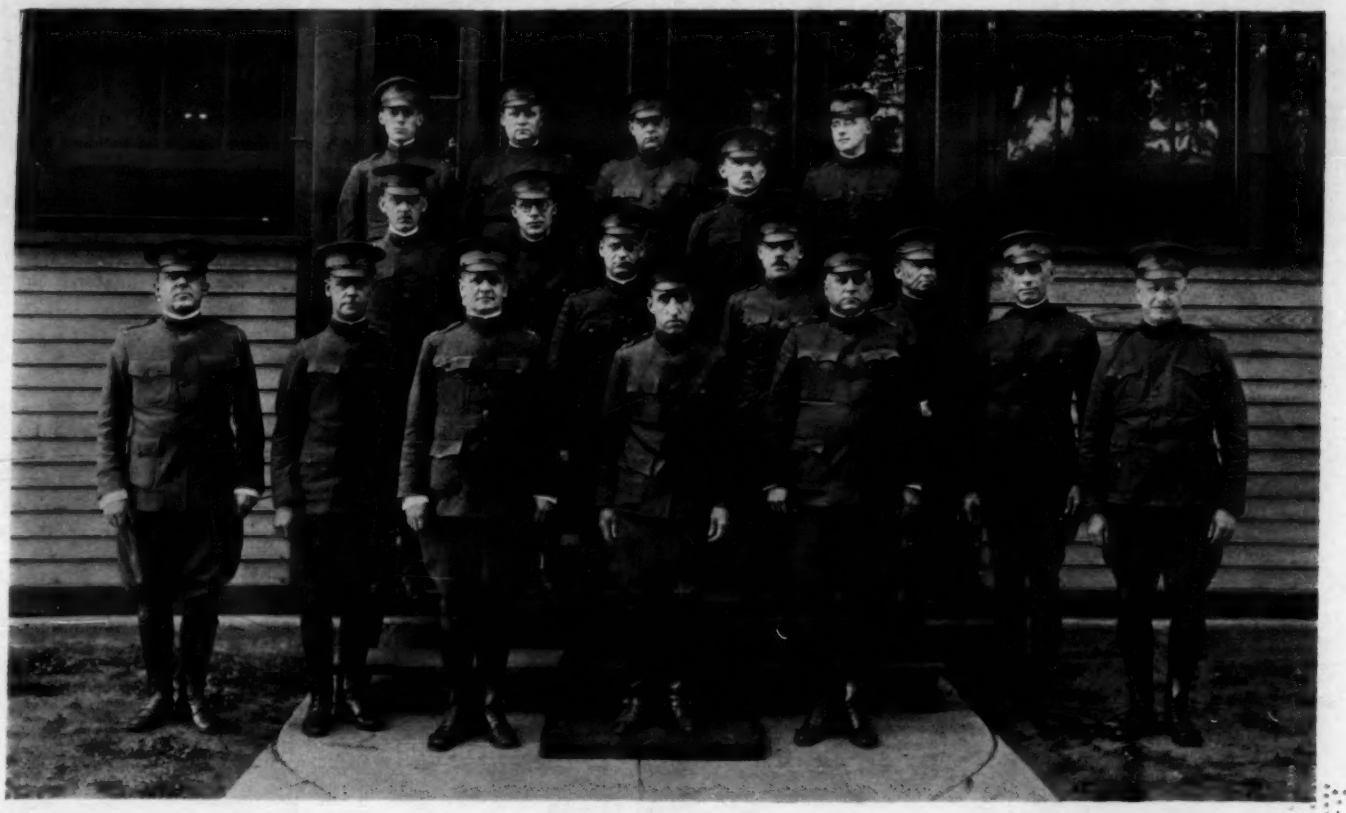
3. CARE AND TREATMENT IN CIVIL INSTITUTIONS

At the beginning of the mobilization, the Surgeon General wrote to the authorities in the different states, asking them if they would co-operate in relieving the Federal Government of the care and responsibility of recruits, in whom insanity existed prior to enlistment, or in whom it was not an incident to service. It was evident that cases of this character should not be a charge on the Federal Government. Most of the states thus communicated with responded with splendid and patriotic spirit. It gives me great pleasure to express for the Surgeon General to the state authorities who co-operated in this way, his great appreciation of their help. The arrangement in general is, with certain variations depending upon different methods of handling insane in the different states, that the military authorities would send patients of the above class to a point designated by the state authorities, and would then release the patient to the state authorities. This method has been of great assistance to the Medical Department of the Army, and, as will be shown later, has not put an excessive burden on the states. It has worked most satisfactorily when there was a central board with which all Commanders could communicate, and which could in turn at once indicate

the special institution to which the recruit in question should be sent. In certain states not provided with committing officers the Surgeon General's Office has met the moderate fee which has been asked by physicians who executed the commitment papers.

For the use of insane officers, an offer by Bloomingdale Hospital, White Plains, New York, of fifty beds, has recently been accepted by the Surgeon General. The proximity of this hospital to the port of debarkation will make these beds particularly useful for expeditionary cases. The beds are administered as of General Hospital No. 1, which is located only a few miles distant from White Plains. Thus the patients will remain under military control, although actually cared for by the personnel of Bloomingdale.

St. Elizabeths Hospital, under the Department of the Interior formerly known as the Government Hospital for the Insane, at Washington, D. C., receives the insane from the residents of the District of Columbia and the insane from the military and naval establishments. Anyone may be sent to St. Elizabeths Hospital who is a member of the military establishment. An enlisted man, for example, who becomes insane from any cause may be ordered to St. Elizabeths for care and treatment. The hospital is constantly receiving patients, for whose cases the question of "line of duty" has not been considered, they having been sent with a request for an expression of opinion as to whether the cause is or is not "in line of duty." The Superintendent expresses himself when the facts warrant and whatever action has been taken by the War Department has never been considered to affect in any way the continuation of the care of the patient at the hospital. The question of "line of duty," however, becomes vital after the patient has been discharged from the military establishment. Then the benefits of the hospital are only open to him, provided his disability can be traced to service conditions. In other words, the whole thing may be summed up in a very few words by saying that all of the members of the military establishment are admissible to St. Elizabeths for care and treatment. After their discharge, however, they may only be admitted when their mental disability can be traced to causes which arose during and were produced by the service. This latter even applies to people who have been discharged from the service and who may become insane within a period of three years. If the insanity is traceable to the service they are entitled to the benefits of the

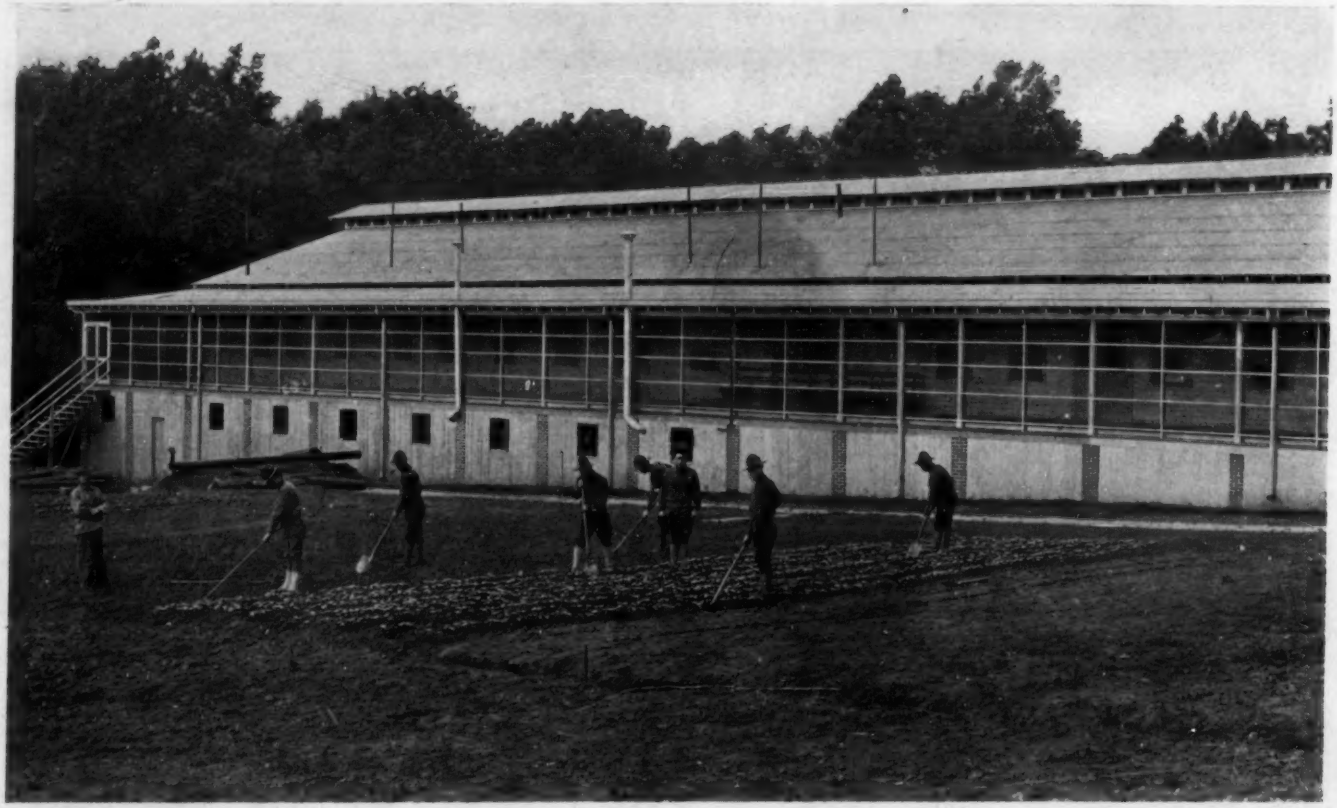


U. S. ARMY GENERAL HOSPITAL NO. 4, FORT PORTER, BUFFALO, N. Y., COLONEL WOODSON AND STAFF

From left to right (on ground): 1st Lieut. J. H. Baker, ret.; Capt. Homer E. Safford, M. R. C.; Capt. A. E. Brownrigg, M. R. C.; Lieut. Col. Thomas D. Woodson, M. C., N. A.; Capt. Paul Compton, San. Corps, N. A.; 1st Lieut. O. E. Coleman, M. R. C.; Capt. J. A. Heatly, M. R. C.
(On first step): Capt. S. L. Goodrich, M. R. C.; 2d Lieut. E. F. Held, Q. M. C., N. A.; Capt. W. T. Patterson, M. R. C.
(On second step): Capt. J. G. Stowe, M. R. C.; 1st Lieut. P. J. Quinn, Chaplain, N. A.
(Rear row): 1st Lieut. L. O. Murphy, D. R. C.; Capt. L. R. Bice, San. Corps, N. A.; Capt. C. H. Mackey, M. R. C.; 1st Lieut. H. E. Cooper, M. R. C.; 1st Lieut. B. F. Hauenstein, M. R. C.

PROFESSIONAL STAFF, PHYSICIANS, NURSES, ATTENDANTS, NEURO-PSYCHIATRIC WARDS, U. S. ARMY HOSPITAL NO. 6, FORT McPHERSON, GEORGIA

NEURO-PSYCHIATRIC WARD, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA



NEURO-PSYCHIATRIC WARD AND OCCUPATIONAL CLASS IN WAR GARDENING, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA

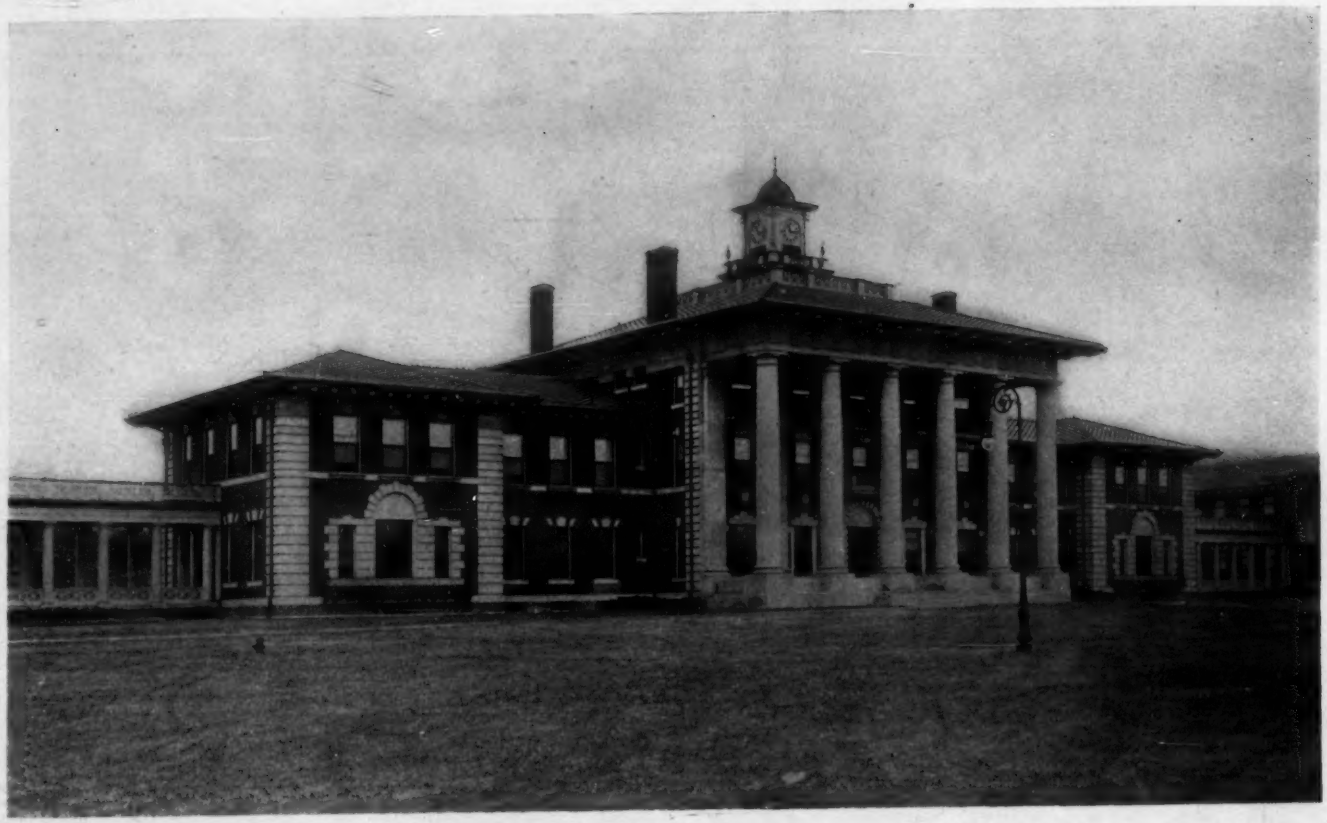
A NEURO-PSYCHIATRIC WARD, WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.

BASKET MAKING AND WEAVING, NEURO-PSYCHIATRIC SERVICE, WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.

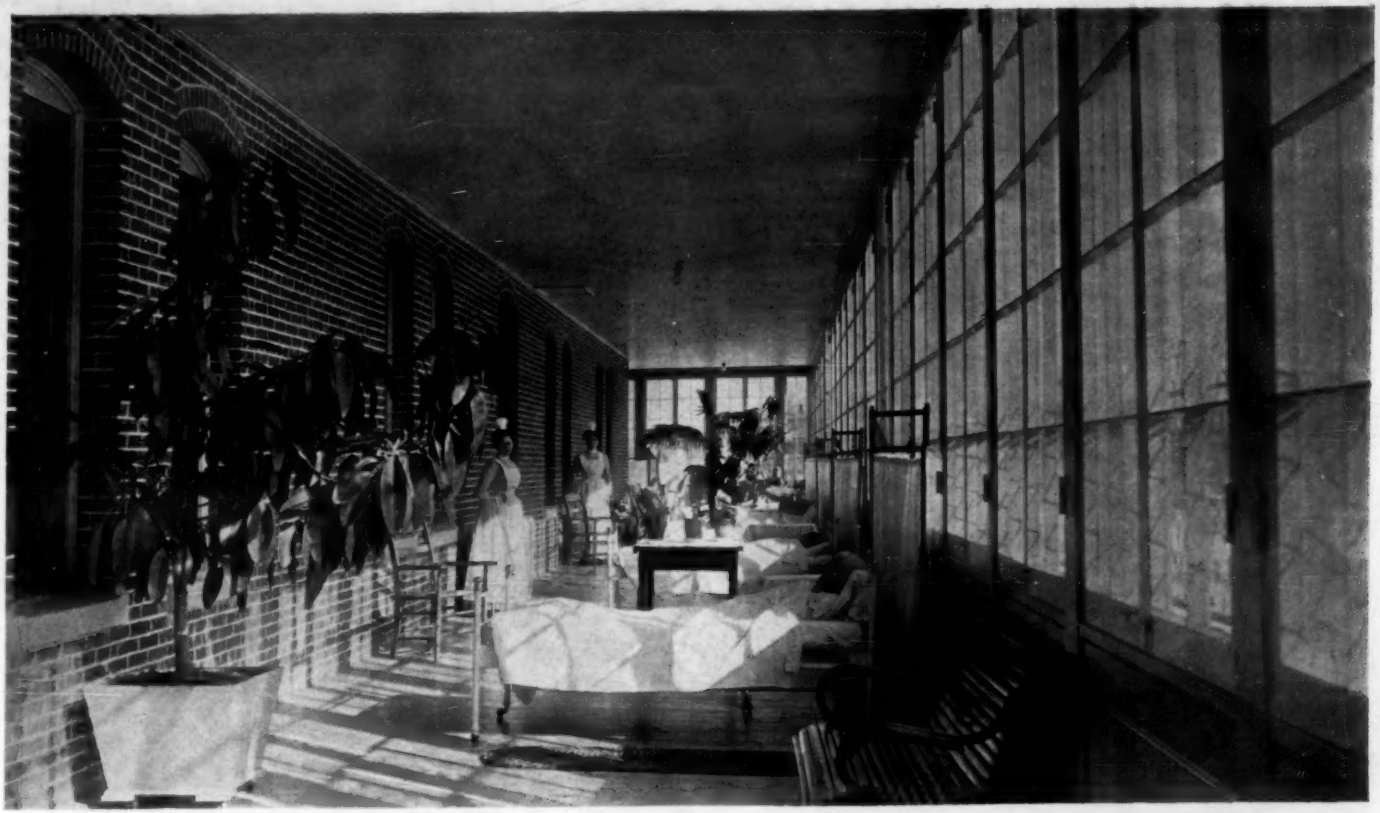
GARDENING, NEURO-PSYCHIATRIC SERVICE, WALTER REED GENERAL HOSPITAL, WASHINGTON, D. C.

NURSES (ARMY NURSE CORPS AND ENLISTED MEN, MEDICAL DEPARTMENT), U. S. ARMY GENERAL HOSPITAL NO. 4, FORT PORTER, BUFFALO, N. Y., IN FRONT OF NEURO-PSYCHIATRIC WARDS

PSYCHIATRIC WARD, U. S. ARMY GENERAL HOSPITAL NO. 4, FORT PORTER, BUFFALO, N. Y.

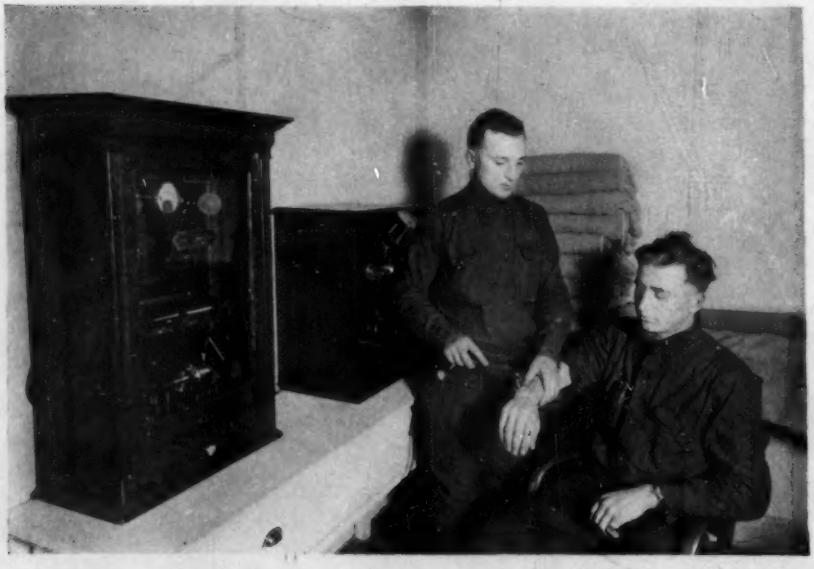


ST. ELIZABETHS HOSPITAL, WASHINGTON, D. C.

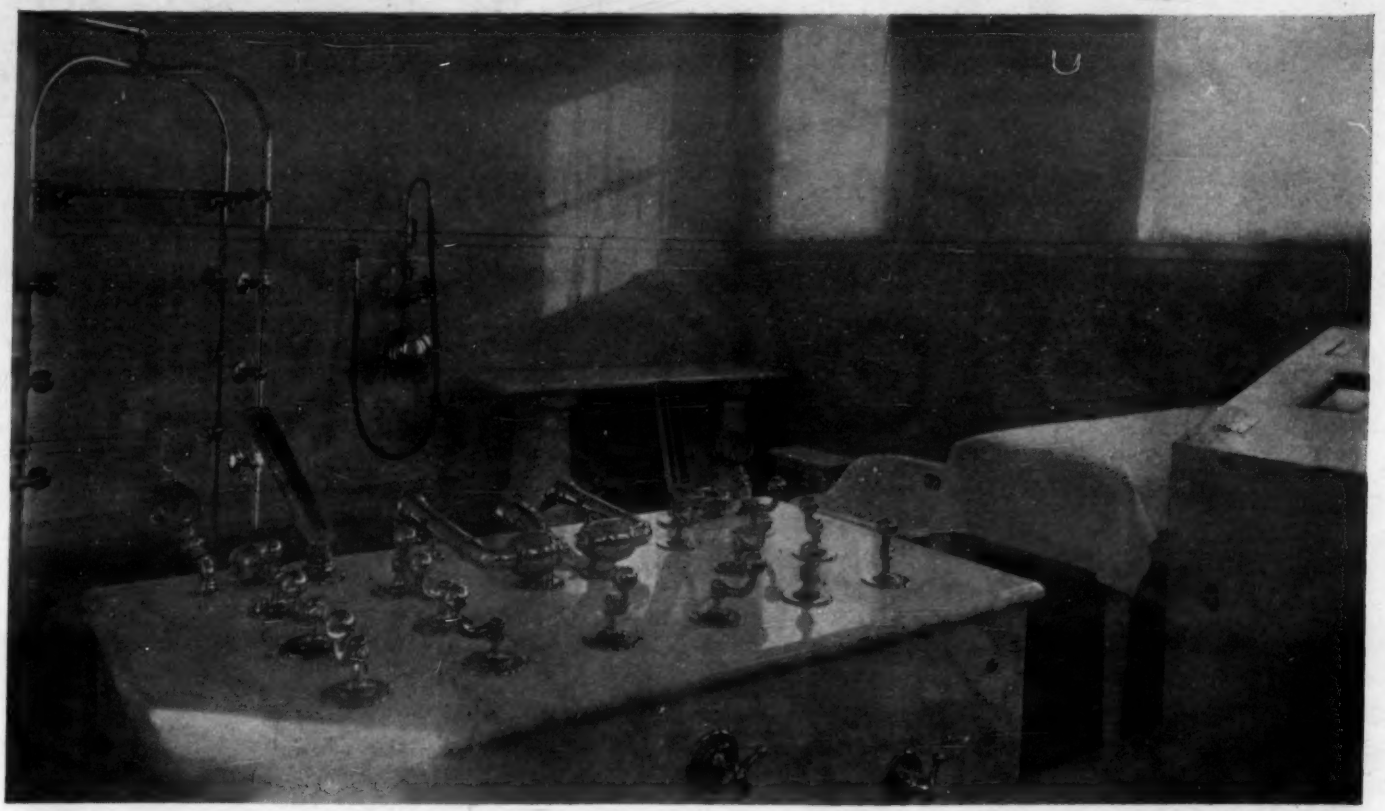


SLEEPING PORCH, ST. ELIZABETHS HOSPITAL, WASHINGTON, D. C.

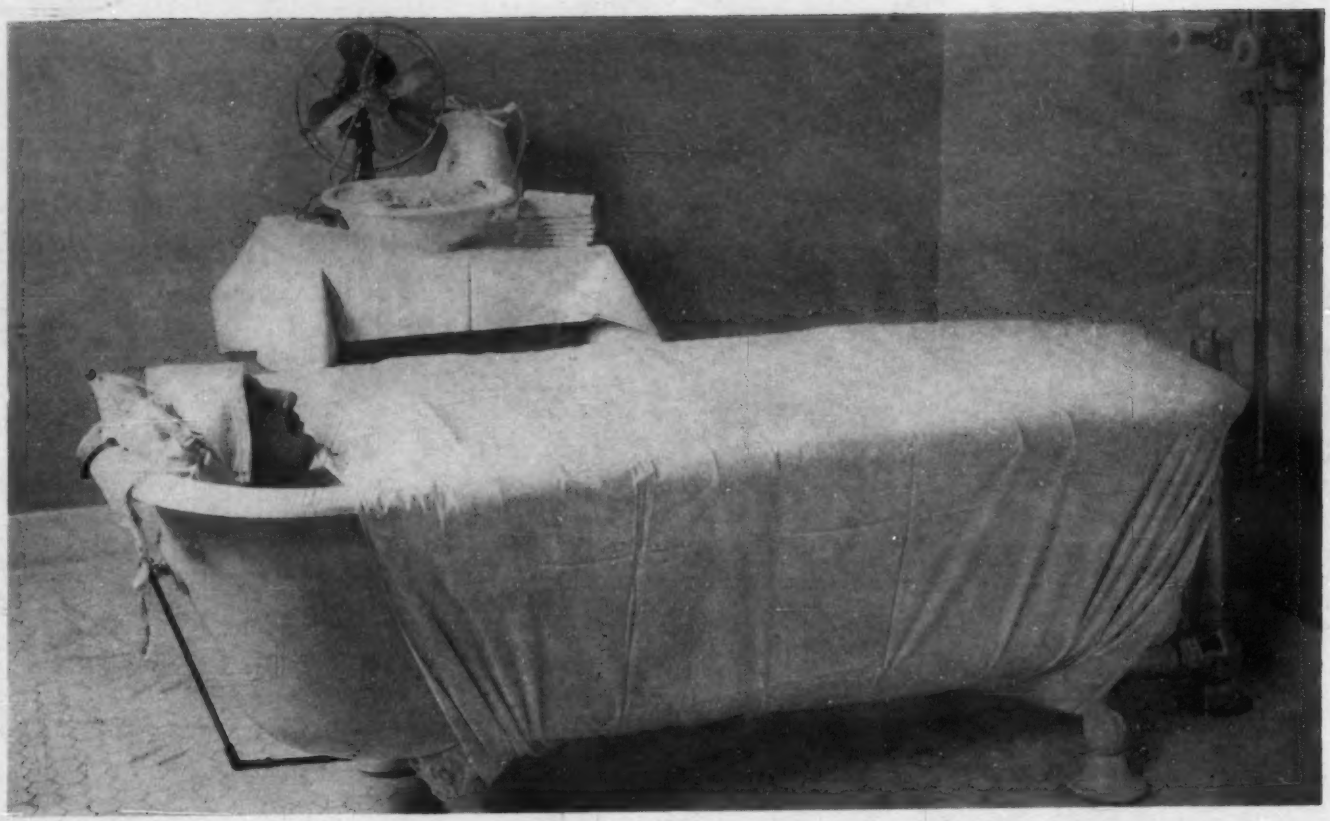
PHYSIO-THERAPEUTIC EQUIPMENT, NEURO-PSYCHIATRIC WARDS, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA



ELECTRICAL EQUIPMENT, NEURO-PSYCHIATRIC WARDS, U. S. ARMY GENERAL HOSPITAL NO. 6, FORT McPHERSON, GEORGIA



TYPE OF HYDROTHERAPEUTIC EQUIPMENT, NEURO-PSYCHIATRIC WARDS, U. S. ARMY GENERAL HOSPITALS, MENDOCINO STATE HOSPITAL, TALMAGE, CALIFORNIA



TYPE OF HYDROTHERAPEUTIC EQUIPMENT (CONTINUOUS BATH) INSTALLED IN NEURO PSYCHIATRIC WARDS

hospital, otherwise not. The definitions of the various classes admissible to the hospital may be found in the Revised Statutes, Section 4843.

Until the present great increase in the size of the Army, St. Elizabeths had always been able to meet the requirements put upon it, but it could not be expected to do so with a larger Army. So the Superintendent, Dr. William A. White, in the summer of 1917, increased his budget for the following year to meet the increased number of patients expected, and also to provide for additional temporary buildings which are now in course of construction. But in addition to that he did a very wise thing. He secured Congressional action which confers on the Secretary of War for the present emergency, the authority to designate an undetermined number of civil hospitals, to be entitled to receive patients of every class exactly as St. Elizabeths now receives them. In other words, whenever it becomes necessary it will be possible to create arrangements with civil hospitals, so that they become, practically, temporarily branches of St. Elizabeths. The purpose behind the arrangement was not only to prevent St. Elizabeths from becoming suddenly full, but also to do away with the necessity of transporting to Washington patients from all over this great country. The previous arrangement, that was satisfactory for a small Army, would be unwieldy for a large Army. So far, the only hospital which it has been found necessary to have designated by the Secretary of War as on the St. Elizabeth status is the Mendocino State Hospital, Talmage, California.

4. EVACUATION: ARMY REGULATIONS

Prior to the present war all discharges from the Army by reason of insanity were made solely upon the order of the Secretary of War. This meant that all the papers in the cases of this kind were forwarded by local commanders to Washington, having first passed through Department Headquarters. This method implied delay before an insane man could be separated from the service, or be released to the custody of his friends, or sent to St. Elizabeths Hospital for treatment. One of the first things which was done to insure a great expedition in these matters in the new Army was the issuance of a general order which extended the authority of discharge to division and department commanders. This decentralization of authority was embodied in the changes in Army Regulations (C. A. R. No. 64, Amending Art. XLV,

¶ 464–70) which changes effected other improvements in the care and disposition of the insane.

Whenever military necessity permits, it is distinctly to the advantage of the Government to have a period of probationary enlistments of a few weeks. During that period many defects come to light which may have been passed over at the first hurried examination. During such a period, recruits unfitted for military service can be returned much more easily to civil life. Until they have taken the oath, the Government is less obligated to care for them than afterwards. For the insane of this class the following provisions now exist.

Applicants for enlistment and drafted men who are found to be insane after arrival at depot, post or camp, and before the completion of their enlistment by oath, muster in or otherwise, are disposed of as follows:

(1) Those whose liberation is unattended by danger to themselves or others, are rejected and disposed of under regulations governing disposal of other rejected recruits. In other words, cases of this class are disposed of in the same manner as are purely physical disabilities.

(2) Those whose insanity is of a type that would probably make their liberation a source of danger to themselves or to others are delivered to the civil authorities authorized by law to apply for commitment, of the place where they applied for enlistment or whence they were drafted.

This latter provision requires, if it is to be carried out in the sense intended, a close co-operation on the part of the civil authorities. It clearly points out the necessity of every state's having a central administrative point which can either receive emergency cases of insanity, residents of the state, or nominate the hospital to which such patients may be sent directly.

LINE OF DUTY

For the purpose of defining the Government's liability, the War Department must attempt to distinguish between disabilities which are acquired in the service and those which are not. Questions affecting care and treatment as well as pensions, are involved. In mental cases the question is particularly difficult to decide, but has become somewhat more concrete through recent orders; General Order No. 47, II, May 11, 1918, 710 A. G. O., provides that "any soldier who shall have been accepted on

his first physical examination after arrival at a military station as fit for service, shall be considered to have contracted any subsequent determined physical disability in "line of duty" unless such disability can be shown to be the result of his own carelessness, misconduct or vicious habits, or unless the history of the case shows unmistakably that the disability existed prior to entrance into the service. The same ruling applies to the cases of officers who have been passed as fit for service on physical examination upon entrance into the service." This order, in which the term physical disability includes mental disabilities, admits that insanity may arise in line of duty unless the history shows its prior existence. As in the Manual of Instructions for Medical Advisory Boards, Form 64, P. M. G., it is provided that a previous mental disease should exempt from military service when it was severe enough to necessitate hospital treatment; it would seem that mental disease might be regarded as not having existed previously unless there was a record of hospital treatment for that cause. It is probable therefore, that disability boards will find more cases of insanity as having arisen in "line of duty" than they have in the past.

Before being recognized as insane by the military authorities, the patient must have passed before a board of at least two medical officers, one of whom shall, whenever practical, be a specialist in nervous and mental diseases. The examination shall preferably be made in hospital and in the special ward for nervous and mental diseases, if there be one; and the board will not make its report until the person being examined shall have been observed for a reasonable length of time. The report gives the diagnosis, a detailed account of the medical history of the case, and a statement as to whether the disability was or was not incurred in "line of duty"; also a statement as to whether the patient, if discharged from the service, can be released from control without danger to himself or others, and the board's recommendation for or against the patient's transfer for the treatment to an institution. If the insanity is reported as "in line of duty" and the board recommends treatment in a hospital of the class of St. Elizabeths, the patient is transferred to the institution on the order of a division or a department commander, or of the Adjutant General of the Army. "Non-line-of-duty" cases are handled in the same way, except that, they are not eligible after discharge to be cared for at the expense of the United States. But the new

regulations provide provisionally for those cases in which the question of "line of duty" is in doubt or cannot be immediately decided, or in which care by home state or relatives is not immediately available. Patients will not be turned loose on the streets, in other words.

RATIO OF INSANITY TO TROOP STRENGTH

While not insisting on any rigid deductions from our still incomplete experience, certain facts stand out as significant even if not finally established. One of these is that the ratio of insanity to troop strength is much less than has been anticipated and that the elimination at the source, by means of the neuro-psychiatric examination, has been largely responsible for this.

In preparing for the insane of the new Army it was difficult to obtain figures as to numbers upon which definite estimates could be based. Those compiled previously to this war did not reveal what efforts, if any, were made to eliminate the insane at the source, nor did they state whether or not the cases required custodial care. It was known that a modern army, whether in England, Germany or the United States, would produce in one year, three insane men per thousand troops during peace, and that this number would be doubled in war, particularly in expeditionary campaigns. But it seems certain in all these statistics the term "insanity" was employed to include all the mental cases mentioned as constituting the 83.7 % of the present statistics, without information as to the effect of the mental condition on the individual's behavior or whether or not he required custodial care or could be released from control without danger to himself or to others.

Certain information concerning the ratio of hospital cases of insanity to troop strength were available from the statistics of St. Elizabeths, although it must be remembered that these by no means represent the total cases embraced under the term "insanity," as many of the acute psychoses, so common in the military services, recover in a few weeks, and do not reach St. Elizabeths. Army admissions to St. Elizabeths during the years 1914–1917 are as follows:

1914	77
1915	105
1916	179
1917	275

It was believed that the excitement and unexpectedness incidental to the preparation of a large Army would bring about a proportionate increase in that number. This belief has proved not only to be incorrect, but the ratio of insanity to troop strength has shown a decline.

In the first four months of 1917, St. Elizabeths' admissions from an Army of approximately 136,000, were 58. In the first four months of 1918, with an Army of approximately 1,000,000, they were 92. In other words, admissions to St. Elizabeths had not doubled although the Army had become eight times as large. The total number of admissions from October, 1917, when the mobilization began, to May 1, 1918, is 177. Up to the same date, 300 cases are reported as having been received back by institutions of the different states, making a total of 477 cases of insanity requiring custodial care, produced in eight months during the mobilization of an Army considerably over 1,000,000 men, instead of the 2000—3000 that had been expected. In view of the close association between delinquency and mental disease and defect, it is pertinent to note also that the military delinquents are much fewer than had been provided for.

MILITARY SERVICE AND INSANITY

This diminished percentage of insanity in any Army systematically examined with the view of eliminating those who might become insane, seems to contribute something to the answer of a question of military psychiatry which has never been satisfactorily answered. The question is this: Does Army life make men insane? The question is especially important in a warfare which involves the whole nation, as bearing upon the economic value of psychiatric examinations. As far as epilepsy and mental deficiency are concerned, the present statistics do not throw much light. While camp conditions might easily, and as a matter of fact often do, give rise to nervous episodes in the mentally deficient, they have nothing to do with the underlying cause. The same may be said of epilepsy. The frequency of attacks in epileptics may be increased after entering the Army, but figures so far obtained do not justify the assumption that a potential epileptic under peace conditions is converted into an actual one by Army life. But the matter is quite different with the psychoneuroses, constitutional psychopathic states and dementia praecox. It seems that even in the training camps any of these conditions

may become active and conspicuous through the requirements of military service when they had not manifested themselves to a degree to be incapacitating in civil life. It is not believed that this conversion of a potential psychosis into an actual one in the camps is a result of hardship or physical causes. It is believed rather to be a psychological result from disharmony with new and rigid conditions which the neurotic, who is so intensely individualistic, finds it impossible to adapt himself to and so breaks down. This explanation holds true for those who have volunteered quite as much as for those who have been drafted.

As far as the expeditionary forces are concerned, the time has not yet come to explain the method of production of psychoses. Most of the wounded so far returned had departed for France before the neuro-psychiatric examinations had been established. Among them there is a percentage of nervous and mental disease of twenty-five, a percentage that seems destined to decrease as the figures more and more concern the examined Army.

Our experience indicates that a pronounced psychopathic constitution and military service are antagonistic. It is believed on the other hand that psychoneurotics who might render excellent service in their civil capacity, become incapacitated by the change in their habits of living however patriotically they may have sought it. It is also believed that the Army fares better without them.

Instances can doubtless be brought forward to prove the contrary. Great generals may be cited as epileptics, great leaders who were fanatical to the point of insanity, and others who with unmistakable symptoms of psychoses were nevertheless famous strategists; but these exceptions are rare and do not affect the rule, now well established, that those expected to work effectively and harmoniously under the orders of others must be of sound nervous system.

A SURVEY OF WAR NEURO-PSYCHIATRY*

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IT has been my privilege to have a wide vista of neuro-psychiatric work, as prior to my present position I was in charge of wards in the Neurological Section of the Royal Victoria Hospital, Netley, where a large percentage of the cases with psycho-neurotic disorders were admitted. The British medical world was ill prepared for the treatment of these patients, for previously little scientific interest was taken in such sufferers. The average neurologist after a careful examination, and finding no sign of organic change would label the case "functional," and apart from some banal advice, the use of simple physical measures such as electricity, massage and hydrotheraphy, with the probable administration of that presumed panacea for all nerve troubles, "bromide," nothing further would be done to endeavour to search for the real pathological basis. As Freud[1] well puts it—"The doctor acts quite differently towards hystericals than towards patients suffering from organic disease. He will not bring the same interest to the former as to the latter, since their suffering is much less serious, and yet seems to set up the claim to be valued just as seriously. But there is another motive in this action. . . . Before the details of hysterical symptoms, all his knowledge, his anatomical, physiological and pathological education, desert him. He cannot understand hysteria. He is in the same position before it as a layman. And that is not agreeable to anyone who is in the habit of setting such a high valuation upon his knowledge. Hystericals, accordingly, tend to lose his sympathy; he considers them persons who overstep the laws of his science, as the orthodox regard heretics; he ascribes to them all possible evils, blames them for exaggeration and intentional deceit, 'simulation,' and he punishes them by withdrawing his interest."

This unsympathetic attitude was so extremely prevalent, that the neurotic soldier was upon no "bed of roses," unless by chance he happened to get into the hands of a medical officer whose outlook was widely different. It was no wonder then that the question

* Publication approved by British War Office.

of high explosives as a possible factor to explain psychoneurotic symptoms should have been jumped at by the medical profession with the result that every nervous disturbance without visible signs of injury was labelled shell shock, and learned lectures and treatises were given forth showing how the concussion, even at a distance, and the formation of noxious gases in the vicinity would account for all that was seen in these cases. The followers of this theory were many, and the treatment which naturally would be based upon it, known as the so-called "common sense treatment," which involved only rest and quiet surroundings, resulted in the great majority of the sufferers becoming chronic invalids and being finally discharged from the service with pensions. Major A. F. Hurst (Proceedings, Royal Society of Medicine, Section of Neurology and Psychiatry, April, 1918) states from his own experience, "There are hundreds of men suffering from war neuroses scattered through the central and convalescent hospitals of England, where they spend many weary months without adequate treatment. At the end they are often invalided from the service still suffering from their original symptoms, like two men admitted under Captain Symns, who were working on a farm the day after their arrival at Netley, *although only ten days earlier they had been awarded 100 per cent pension for total incapacity due to hysterical paraplegia.*"*

Our medical education and organization are mostly to blame for the limited number of physicians capable of undertaking neuropsychiatric work. Our neurologists have no psychiatric or psychological training. The mind is studied only in the light of neuronic functioning. The psychiatrist on the other hand usually has no neurological training and the British School of Mental Medicine is so deeply imbued with materialism that the majority of its members earnestly proceed with the search for some mythical toxins as the one and only causative factor of mental abnormality, with the result that the human factor, the individual conflict with the environment and the social and biological standpoints are quite lost sight of. The clinical war experiences, nevertheless, have forced the study of modern psychopathology to the fore. Psychopathology in all its various branches has been taken up, and now the most conservative physicians have been heard to state that perhaps there is "something in it."

*The italics are mine.

Suggestion, hypnotism, persuasion, psychotherapeutic conversations, psycho-anaylsis, all have their special advocates, and one special form of treatment is commonly extolled to the exclusion of others. Babinski's pithiatism has seemed readily acceptable to many neurologists, and perhaps it is hardly to be wondered at, for though his view at the time did mark an onward step in the pathology of hysteria, its comparative simplicity is attractive to those who have no scientific desire to seek a more profound pathology. Why the hysteric is so suggestible does not seem to worry the follower of Babinski. That he is so is sufficient, and that is why he so easily attains his symptoms. That hypersuggestibility is found elsewhere besides in hysteria is not taken into account.

Whether the Freudian view of the origin of the neuroses applies equally to the war neuroses is stated by Ernest Jones[2] to be "sub judice" though there is every reason to believe that the psychological mechanisms involved will be to some extent modified by the special circumstances and environment of war.

A good deal of literature has been devoted to neurotic war diseases, but it has mainly dealt with the descriptive side and if the question of etiology or pathology has been spoken of, it has been treated more or less in a superficial way.

Mott[3] lays stress largely upon the physical factors of concussion, the inhalation of noxious gases, and in no way differentiates the different types of nervous disturbance met with, but roughly classifies them all under the heading of shell shock, which renders his statements so largely valueless.

Eder[4] in his small book is dogmatic in regarding the psychoneuroses of war as due to Freudian mechanisms, which he illustrates from his 100 cases; but to the average reader he would seem to take a good deal for granted and rather spoils himself by his extreme reliance on hypnotic suggestion alone by means of which he states he cured 91.5 per cent of his cases, and improved the other 8.5 per cent.

Myers[5] has made many interesting observations on cases he met with in France, but his studies were limited to certain types of disorder.

Hurst,[6] in common with so many other authors, speaks vaguely of the effect of fear and other emotions as causative factors, but throws no light on the essential pathology. He also is a supreme believer in Babinski's pithiatism and has no sympathy with modern psychopathological trends.

Farrar,[7] has given us much interesting matter and his discussion on the etiology of the war neuroses from the psychogenic standpoint is distinctly edifying and enlightening.

The French have added little to our knowledge of psychopathology, although excellent and careful clinical studies have been made. Babinski's well known views are put forth in a Military Medical Manual,[8] and ably seconded by Roussy and Lhermitte.[9] By far the most illuminating writing on the subject of the war neuroses is given us by MacCurdy[10] who traces the various symptoms "ab initio," points out the various mental conflicts that take place in the patient and the mechanisms involved in the production of the final clinical picture. He deals, however, almost entirely with conversion and anxiety hysteria, but devotes some small space to consideration of the relation between functional cardiac trouble and psychogenetic factors. It seems to me to be doubtful if he is correct in assuming that man's aggressive instincts are "sublimated" in active warfare and that the commencement of the neurosis is due to the failure of this sublimation whereby he becomes more individualistic and so feelings of personal harm become paramount. If by sublimation we infer the drafting off of instinctive energy into higher channels such as takes place in modern civilization in the form of competition in sport, business and position in life generally, it is a moot point whether or no the combative spirit and even love of destruction of the enemy is not a loss of that sublimation from the loss of inhibition which is now sanctioned by society and promoted by herd instinct. From this point of view the onset of the neurosis would mean a tendency to a return of the sublimation with a correlated weakening of the herd influence. Much depends on our exact meaning of the word "sublimation."

The point is an interesting one and I think merits further discussion. The last work to appear on this subject by the Resident Medical Officer of the National Hospital for the Paralysed and Epileptic, London,[11] deals almost entirely with the motor neurotic disorders and adds nothing to our pathological knowledge, but only illustrates the extreme efficacy of treatment by persuasion in these particular cases.

Time and space will permit me to give only a brief summary of my clinical experiences in the war neuroses. I would classify the cases as follows:

1. Neurasthenia
2. Hysterical manifestations
   a. Conversion Hysteria
   b. Anxiety Hysteria
   c. Amnesic Fugues
   d. Amnesias
3. Obsessional Neurosis
4. Convulsive Attacks
5. Stupors
6. Puerilism (Mental)

1. NEURASTHENIA

This term even at the present day among the majority of men is used in so loose a way that almost any nerve disorder short of insanity, that is not patently hysterical, is thus connoted. And yet modern psychopathologists have marked out a very definite syndrome as designative of this disease, and when other morbid symptoms present themselves it only leads to scientific and nosological confusion to bring this term into use. In the face of this we see hospitals organized for "neurasthenic" officers and soldiers, and Colonel Sir John Collie in a recent article in MENTAL HYGIENE[12], writing at length on this disorder as though it were the prevalent nervous disorder met with in the war, makes such statements as the following, "Most, if not all, of the cases of neurasthenia arising in the Army are the result of actual concussions (shell shock), or the conditions prevailing in modern warfare." "It is obvious that the origin of the *conglomerate collection of symptoms** which go to make up the content of neurasthenia is mental." Greater scientific accuracy is required than this, after the 40 years since it was described by Van Deusen. Ernest Jones states,[13] "The term should be restricted to its primary meaning of a fatigue neurosis, the cardinal symptoms of which are an inordinate sense of mental and physical fatigue, difficulty in concentration of attention and application to work, sense of pressure on the head, spinal irritation. Gastro-intestinal symptoms such as constipation and flatulent dyspepsia also occur but are more closely related than the other symptoms to complex psychogenic factors. Hypochondriacal symptoms, most often genito-urinary, form a common complication and are definitely psychogenic in origin. Even the syndrome is only to be regarded as true neurasthenia in contradistinction to neurastheniod, after it has been

* The italics are mine.

shown not to be secondarily produced by some other disease, i. e., as a toxic state as a sequel to influenza or typhoid."

In my experience with the war neuroses neurasthenia is decidedly rare and I only met with one or two cases that could properly be brought under this heading. Eder and Ernest Jones concur in this view and Hurst tells me he does not meet these cases in England though he did so when on duty in the Servian campaign. However we may look on the pathology of this disease, the fact remains that the above syndrome is uncommonly met with. That the exhaustive factors of warfare *per se* will produce neurasthenia is of course untenable for a moment, otherwise during the late events in France we should have had ample evidence of the fact. Whether Freud is correct or not in his ideas that neurasthenia is brought about by excessive masturbation or frequent pollutions, is beside the point. Undoubtedly the disease so frequently termed neurasthenia is really anxiety hysteria, which disorder is so ably discussed by MacCurdy in the article already referred to.

2. HYSTERICAL MANIFESTATIONS

The large bulk of the neurological disorders met with fall under this heading. Conversion hysteria is seen more amongst the men, while anxiety hysteria is more prevalent among the officers. Every possible variety of somatic disturbance, both sensory and motor may be met with in the former and in both forms physical and mental symptoms always co-exist, but it is the latter which require investigation and treatment. In this rapid survey it will serve no useful purpose to detail the manifold clinical pictures that may present themselves. Paraplegic states are very common following upon physical traumata, as are also disorders of gait and involuntary muscular movements. Speech disorders are frequent including mutism, aphonia and stammering. Hysterical deafness often is combined with mutism after shell shock, while functional blindness, diminished vision and blepharospasm are also met with. Monoplegia and local partial paralysis are more commonly met with as complications or sequelae of definite injuries and are seen more in the surgical wards.

For an insight into the various psychological mechanisms which may be involved in the production of the various somatic symptoms one cannot do better than refer to Eder's treatment of the subject in his work on "War Shock."[4] Sensory abnormalities are

of course constantly found but usually in conjunction with motor ones.

In *anxiety hysteria* the most prominent symptoms are mental—a feeling of anxiety and dread without definite cause, sleeplessness often with terrifying dreams, headache, great exhaustion after trivial mental or physical effort, constituting the most prevalent type while special phobias may complicate the picture. The psychopathology of this disease is of great interest. As already stated it is much more commonly seen in officers whose responsibility is so much the greater and whose intelligence tends to prevent them from having conversion hysteria. MacCurdy, in his article already alluded to, discusses excellently the gradual development of symptoms through fear repression and mental conflict until some accidental trauma lights up the fully fledged anxiety state. Readers should refer to that, for no other writer has so clearly and so adequately thrown light upon its pathology. MacCurdy shows that the physical and emotional trauma of high explosives is only the last straw which sets aflame and brings to a head suddenly a neurotic state which has been more or less slowly incubating for some time, but I see no reason why, at times such a trauma should not of itself produce neuropathic symptoms in those who had much dynamic repressed material prior to war experience. One effect of the trauma will be to bring about a certain amount of loss of inhibition whereby failure of repression may easily come about. Any factor causing loss of conscious control may temporarily bring previously repressed complexes to the surface in some distorted way in a psychopathic constitution, and I have certainly met with such causes among the war neuroses where no mental conflicts of any moment could be traced immediately prior to the shock. Stanley Hall[14] in his genetic study of fear points out that the effects of shock are always more or less reversionary, that they strike the weak points and may erupt at any phyletic level. Thus shock and probably fear reactions and the diathesis of vulnerability to them may vary much with individuals and in general; to understand them we must not only know the personal history of the subject but something of the laws of heredity and the history of the race. This idea of shock bringing out prehistoric and sometimes even embryonic activities is one which is not sufficiently borne in mind in considering some of the mental reactions met with under war conditions and I therefore introduce it to the notice of workers in

neuro-psychiatric war cases, as I believe that it is of value and should fill a niche in our mental pathology.

The phylogenetic aspect should be considered much more than it is, and I am inclined to believe that some of the stuporose states met with have a likely kinship to the cataplexy seen in animal life. It is doubtless often an endeavour to negate reality, but also may involve a self-preservative negation of movement. At any rate these ideas are suggestive. It should not be lost sight of nevertheless that in perpetuating signs and symptoms the internal secretions may secondarily play a part, and that adjuvant treatment directed to this point may be very helpful. Cannon's work,[15] on the relation of the emotions to the endocrine organs is highly stimulating.

Space precludes me from alluding to other hysterical manifestations met with, but, briefly, *amnesic fugues* are constantly seen in the front line and in all probability more than one such sufferer has been shot for desertion. Court martials on such cases are frequent and in most cases they are officially regarded as temporarily insane, not responsible, and sent home. The patient may or may not have been the victim of some physical or psychical shock. He wanders away a variable distance and when he comes to himself, or gives himself up, or is apprehended, he has a complete amnesia for the period of the fugue. On regaining his personal consciousness he commonly complains of headache, nothing more, though some slight obfuscation may exist for a few days. Quick recovery is the rule and by the time he reaches England there are no objective abnormal signs and no untoward symptoms except the special amnesia, which memory gap can usually be easily recovered by simple psychotherapeutic measures, such as simple association in a passive or hypnoid state or by hypnotic suggestion.

Amnesias of various types without any fugues are also frequently met with, and I am only referring here to those of a purely psychological type and not to those following a definite *concussio cerebri* though these may have some relation to some physical or psychical trauma. The amnesia may involve some limited period of time. It may involve the memory since enlistment, or it may be so retrograde as to involve the whole of life's experiences, so that the patient does not know anything of his previous history, not even his name. It is upon such a foundation as this that secondary personalities are formed. Some of these cases are

difficult to cure but the majority yield to proper treatment with patience. The question as to the genuineness of these fugues has been often doubted more especially by those who having no knowledge of or interest in psychopathological medicine are always ready to see evidence of malingering in such conditions. Nevertheless all competent observers regard these fugues as a very definite pathological state akin to somnambulism. The wanderings of course are not purposeless any more than sleep walking is, and there is good reason for believing that a desire to leave the particular environment involved, which has been very likely conscious at one time and then repressed into the unconscious, is the basic factor. Superficial psychological investigation of such cases support such a theory. It is therefore often unconscious desertion. Consciously, desertion would not be entertained seriously as a mode of reaction to the conflicts that beset them, but in neuropathic individuals when factors produce some loss of conscious inhibition, the unconscious takes control and a fugue results. Many have shown similar tendencies in civil life. The soldier with a normal mental constitution is not likely to show this symptom. I may mention here, that malingering in any form is not commonly met with in the ranks, and if found the individual generally shows on careful examination evidence of some mental defect.

3. OBSESSIONAL NEUROSIS

No remarks are needed concerning this neurosis as they seem to differ in no way from the cases met with in civil life, have often no evident relationship with war experiences and are not frequently encountered.

4. CONVULSIVE ATTACKS

Much work remains to be done with regard to the pathology of convulsive states. We do not talk of epilepsy now so much as "the epilepsies." Of late years L. Pierce Clark has done excellent work showing that epilepsy has so largely a psychogenetic basis, and that by an understanding of its particular mental reactions the condition may be greatly alleviated, if not cured, although the tendency to be epileptic is likely to be of an hereditary nature. When in charge of the neurological wards, I had all the cases of convulsions admitted under my care and it soon became evident to me that the numerous patients sent in as epileptic were not so at all and these largely comprised those who had had no convulsive attacks prior to enlistment. It has in the past been more or

less customary to lay down certain rules as to whether an attack was hysterical or epileptic and types were often met with which according to those rules puzzled the physician. I do not believe there is any hard and fast line to be drawn between the two diseases in this respect, and that all grades of attacks may be met with from typical emotional hysterical attack to the typical epileptic convulsion. Since we are gaining a glimmering into the psychic element in epilepsy, there seems no reason why a definite line can so be drawn. That the condition hitherto regarded as *petit mal* should really belong to the psychoneuroses is more and more forced upon us. Ernest Jones, in a highly stimulating article,[16] states that as a result of our advance in knowledge, the modern tendency has been to base the differential diagnosis in doubtful cases upon an investigation of the mental state of the patient during the free interval rather than upon the symptoms displayed in the fit itself. Hoche[17] has shown that one after another the various features that had been advanced as distinguishing an epileptic from a hystero-epileptic fit have been proved to be non-pathognomonic, until at present it is definitely known that every symptom of a *grand mal* fit, from fixed pupils to sphincter relaxation, may occur as well in functional affections as in idiopathic epilepsy, although of course the features referred to are more frequent in the latter condition. Heilbronner even goes so far as to refuse to diagnose epilepsy in the absence of the characteristic mental changes found in that condition apart from the fits. Binswanger[18] maintains that there is no sharp dividing line, as I have already conjectured, and that one state may pass over into the other. I dwell upon this point because I regard it as of great scientific importance, and in order that neuro-psychiatrists may be upon their guard and not hastily label these states, the differentiation of which is vital to treatment and the future of the patient. American medical officers who are in the position to study such cases from the war zone will have a chance here of making valuable observations and adding greatly to our knowledge in this department of psychopathology. It is easy to understand that complex adaptations required of the soldier, who is recruited more or less suddenly from civilian life, will tend to produce mental conflicts, the reaction to which in many may be some anomalous convulsive attack which requires special care and knowledge. It has been far too much the rule to jump to the conclusion at once that the man is an epileptic and discharge him from the army forthwith

accompanied by a certain stigma which is so often undeserved. Pure epilepsy has in the majority of instances shown itself prior to enlistment.

In the careful and systematic recruiting examination that the American War authorities, I believe, have instituted these psychopathic trends will not be neglected, but taken into account, which will mean the saving of an enormous amount of mental sickness in time to come.

5. STUPORS

Not infrequently stuporous states are met with apart from organic lesion and not distinctive of any psychosis, though it may be difficult at first to differentiate them from dementia praecox. They evidently depend on mental dissociation. An inherent unconscious desire to shut off reality is probably often a basic psychological factor. In severe cases the patient is for a time entirely unconscious of his environment. He seems neither to see nor hear, no words are uttered and there is hardly any or no response to sensory stimulation. Food is automatically swallowed. The condition varies in severity and duration, and he usually gradually regains his normal state. The milder cases can be temporarily roused and their attention gained momentarily. Some may utter a few words connected with war experience demonstrating a dream-like state. Lepine[19] regards these cases as an annihilation of consciousness tired of struggling, the man becoming inert and subconsciousness carrying on. Defense mechanisms are not seen, and the condition may pass on into ordinary sleep. It is a sort of defense of the organism and might be regarded in a biological light. Hoche regards these states as representing one of the typical biological reactions of the organism, a reaction of escape from the environment, and says it is quite in harmony with this and with the growing conviction that the essential motive in the functional psychopathic states of shell shock is a desire to get out of the situation, that stupor seems to be relatively frequent in the war. The stuporous conditions described among the prison psychoses would have largely the same pathology.

6. MENTAL PUERILISM

This condition is somewhat uncommon but pregnant with interest. Two cases came under my observation. Both cases were just over 20 years of age and apart from general nervousness the main symptom they presented was that of childishness in speech

and behaviour. They spoke in a childish way, giggled stupidly, and adopted the attitudes and mannerisms of a spoiled boy of about six years of age. They found pleasure in the most inane trivialities which their ward mates soon found out with the result that discipline often became difficult. One continually reminded us that he wanted his mother. Both patients were very neurotic and one was an only child. As regards the pathology of mental puerilism it seems from a study of the literature on the subject that the symptoms may occur in a variety of disorders, but most of the reported cases were evidently hysterical in nature as undoubtedly the cases under my care were. Many of the cases recorded show that the condition specially comes about when the patient is in a distressing situation and there seems little doubt that it indicates a flight in the imagination back to the happy days of childhood, to the safety and comfort of the mother's arms. One can well understand that in the terrible experiences of active service some psychopaths should develop this symptom as a reaction. It is surprising that there are so few.

I will now pass on to my survey of the psychiatric war work.

GENERAL PSYCHIATRIC CONSIDERATIONS

In dealing with army psychiatry one must bear in mind that we have to some extent different human material than in civil life. There is to a large extent an age limit, mainly from 18 to 40 years, and within certain limits we have in the service men who have been through some sort of recruiting examination, and so presumably a good many mentally unfit are thus eliminated. We have, then, a large body of the male sex only who all have to adapt themselves to more or less the same environment and experiences. In civilian life there is a greater variety of age, individuals, and environment. From this we may deduce the fact that some types of psychoses will not be commonly met with and that the special circumstances involved in war will tend to bring about types of mental reactions not so frequently seen in ordinary life. One must bear in mind that the mere fact of removing an individual from his civilian occupation, taking him out of an existence where within wide limits he has so great liberty of thought and action and placing him in so different an environment in which he finds an unaccustomed iron discipline whereby he has his freedom at once almost entirely curtailed, tends by itself to engender mental reactions which may be abnormal and especially so in those who

have a psychopathic constitution. Before the Commission which sat to enquire into the recruiting problems, in the evidence given by the Military, the opinion was freely expressed that if a man was fit enough to do any form of work in civil life, he was fit to do that work in the Army. Never was there a greater fallacy. Large numbers of cases which have been returned from overseas with psychopathic symptoms freely illustrate the falsity of this statement. The mental factor has not had anything like the consideration it should have received. One can formulate few rules on such a point. Every case should be treated on its individual merits. If there be any evidence of mental maladaptation in civil life, how much greater will the probability be of such under the complex conditions of military life, and still more so in actual warfare.

One can readily understand that in discussing the etiology of war psychoses one has to take a very broad outlook, for the various factors which may predispose and be directly or indirectly causative are manifold and complex. War psychiatry is almost a new study. During the years of modern medicine the soldiers taking part in active warfare have been more or less trained and picked men and for the first time the civilian population has been more or less suddenly called upon to fill the ranks of large armies. The conditions of warfare too have suddenly changed so much. Enormously high explosives, poisoned gases and flame fire have been added to the army's armamentarium, while bombing from the air and the peculiar methods of trench strategy have added so greatly to the mental and physical strain of the combatants. Except for some psychiatric publications by Russia in the Russo-Japanese war, the only literature on military psychoses has previously treated of the findings in time of peace. Richards,[20] tells us that it was in the Russo-Japanese war that for the first time in the history of the world mental diseases were separately cared for by specialists, from the firing line back to the home country. Some detailed statistics thus come to hand which I do not purpose to discuss here, but only draw attention to the surprising statement that 22.5 per cent were said to consist of epileptic psychoses and to the fact that 19.5 per cent were stated to be alcoholic in origin.

In considering the factors tending to bring about the mental breakdown, one should, I think first bear in mind the point I have already alluded to elsewhere, that is, that the necessary abnegation

of free thought and conduct, combined with the fact of becoming subject to an unaccustomed iron discipline, is sufficient, especially in the psychopathically disposed, to produce mental reactions of an unhealthy type. Such reactions must be helped on, too, to a great extent by associative factors, the leaving of home and those near and dear to them and in many cases dependent on them, the blighting of ambitious hopes in civil life, the fear of financial ruin, the loss of business and may be the dread of future incapacity or loss of life. Doubtless the herd instinct with the average man tends to overwhelm these incapacitating thoughts and feelings and the "crowd emotion" gradually but surely begins to fill him with martial and patriotic sentiments, so that before long he is straining hard to be an efficient soldier and even longing to come to grips with the foe. Nevertheless, many experiences may render him individualistic again, and it is then that mental conflicts are set up which in the predisposed may result in psychopathic reactions. Should he have had previous mental breakdowns his outlook in any circumstances is worse, but he is usually ashamed to mention the fact at the time of medical examination and even when known to the authorities the fact is often ignored. I have had a man under my care whose history sheet was marked under the heading of "slight defect," but not sufficient to cause rejection: "Two previous attacks of insanity." Generally one hears of psychoses as tending to be brought about by *stress and strain* of warfare. So vague a term would comprise mainly the factors of mental and physical exhaustion, and climatic conditions and *per se* would not produce mental disturbance probably without other issues being involved.

In my opinion the so-called *exhaustion psychosis* requires much pathological investigation. Intense physical exhaustion alone can produce no psychosis. The war correspondent of the *Daily Chronicle* wrote, April 3, 1918, concerning the men who had fought for six days and nights: "They were almost tired to death, and when called on to make one last effort after six days and nights of fighting and marching, many of them staggered up like men who had been chloroformed, with dazed eyes and grey and drawn faces, speechless, deaf to words spoken to them, blind to the menace about them, seemingly at the last gasp of strength. Towards the end of this fighting they had a drunken craving for sleep and slept standing with their heads falling against the parapet. In body and brain those men of ours were tired to the point of death.

They felt like old, old men, yet after a few days rest they were young and fresh. It was almost impossible to believe they were the same men. They had washed off the dirt of battle and shaved, the tiredness had gone out of their eyes, and their youth had come back to them." This graphic description pictures very vividly how the extreme limit of exhaustion had been reached and yet a few days rest and all was well with them. If intense exhaustion produces chemical toxins, which, acting upon the nervous system is said to bring about a confusional psychotic state, how can we explain the fact that the experiences written above are quite frequent and yet these men retain their mental health? It is very possible that some lowering of resistance may be left which may predispose the men to a later breakdown, but it is very doubtful if even that would occur without some definite psychogenetic factor. Birnbaum has pointed out that pictures similar to the so-called exhaustion states often occur "solely in consequence of psychic shock, as symptoms of frank psychogenetic disorders, and that there is much to suggest the purely psychic origin of these disturbances in war." Bonhoeffer,[21] was unable to find evidence of exhaustion psychoses as the result of warfare and he states: "A collective survey of war observations demonstrates the great power of resistance of the healthy brain and the insignificance of both exhaustion and emotional factors in the development of actual mental diseases." With regard to the exhaustion, I certainly concur, although the question of the emotional factor is very open to question. Aschaffenburg declares he has seen no cases in which any psychic disturbance worth mentioning has resulted from exhaustion. Clarence B. Farrar concluded from his observations on Canadian soldiers that "the factor of exhaustion may lead to collapse or to acute transitory fatigue states, and if severe and protracted to progressive, physical deterioration. War experience has not established its etiologic importance in the neuroses or psychoses."

For some reason or other the diagnosis of exhaustion psychosis has been added of late to the official nomenclature of mental diseases. This may be harmful in that it may lead many to use this term heedlessly and encourage others not to look further for deeper and more important factors.

The question of *climate* calls for no special mention as it is only part and parcel of the general hardship that a soldier has to undergo, except in the Eastern campaign where heat stroke, sun-

stroke and allied conditions do undoubtedly tend to lower mental resistance. Many of my cases with various psychopathic symptoms, but more especially those who had been in confusional states, blame the heat largely for their breakdown. Whether this was a rationalization or not, I am not in a position to say, but I should be inclined to place heat in the same category as exhaustion, that is, as only being contributory.

Acute illnesses were predisposing and contributory as well. In the East there were many cases of nervous and mental trouble brought on during, or as a sequela to, malaria. The toxin of this disease seemed to have quite a predilection for the nervous system, and amnesic states were quite frequent in its train.

Physical traumata such as head wounds and concussion may lead to the exhibition of mental symptoms through definite interference with, or destruction of, cerebral tissue, and following on such injuries many anomalous states tend to occur. Fugues, amnesias, character changes and convulsive attacks were those mainly seen. We know comparatively little of the pathology of these post-tramautic states, but it is probable that the loss of inhibition brought about by the trauma, thereby permitting latent tendencies and instinctive trends to gain control, is the basis of them. Many authorities regard pre-existing *syphilis* as a marked predisposing cause to nervous and mental diseases in times of strain. I cannot personally say whether this is so or not and the point is a very difficult one to decide. Even if the Wassermann test in a patient be positive, how can one show that this has any real relationship to the psychosis?

Alcohol is of more importance. Although I can only trace a comparatively small percentage of cases to its influence, there are some who take a very opposite view. Lepine,[19] makes the astounding statement that alcohol was the primary and sole cause in one third of his cases and more than half, perhaps two thirds, were influenced by it! His data were based upon 6,000 cases, but is is difficult to see how he could come to such a conclusion. If his deductions are true, one can safely say that the cases met with in the British Army are very different. I am not in a position to give the percentage in my cases at present but I know the ratio is very small. In the Russo-Japanese war the percentage was very high, according to Gerver, and accounted for one third of all the psychoses. He claims, however, that in the last Russian campaign the number of psychoses was comparatively small and

that the decreased rate is due to the total absence of alcoholism, not a single case of alcoholic insanity having occurred. Without knowing more of the conditions under which the Russian soldiers were placed, one cannot draw any hard and fast deductions, but the fact as stated is worth recording. From my point of view, the question of alcohol in the causation of mental disease requires much reconsideration. Apart from the acute intoxications and those chronic states induced by many years of excessive imbibing producing a demential condition, I regard alcohol as only a side issue working with and aiding mental conflict. The drug is so often taken as a narcotic to try and drown a conflict which is either conscious or in danger of becoming so. Alcohol tends to remove inhibitions, aids mental regression and in the end psychological mechanisms are set in motion which mostly bring about the result of having saved the individual mental pain. The effects are compensatory. What would have happened if the alcohol had not been taken? Fenenczi[22] says: "The one-sided agitation of temperance reformers tries to veil the fact that in the large majority of cases alcoholism is not the cause of neuroses, but the result of them and a calamitous one. . . . When alcohol is withdrawn, there remains at the disposal of the psyche numerous other paths to the 'flight into disease.' And when psychoneurotics suffer from anxiety hysteria or dementia praecox instead of from alcoholism one regrets the enormous expenditure of energy that has been applied against alcohol but in the wrong place."

In more or less superficial statistical work it is difficult to make sure as to the absence or not of the alcoholic factor, but in my experience in the war psychoses it is not a glaring one and when present is constantly found not to have been a main issue. Precisely the same syndrome may be met, with or without alcohol as an adjuvant. One must not take up much space here in discussing this interesting problem. The topic will be touched on again later in speaking of the clinical material itself. There only remains to mention *mental conflict* as the last but most important etiological factor in the production of the war psychoses. Now that modern psychiatrists are more and more studying the psychology of mental diseases, they are tending *pari passu* to find mental conflicts as the *fons et origo* of the psychoses. The mechanisms involved, the distortions and disguises which those same mechanisms have brought about, and the end results in more

or less definite clinical types have been much studied and formulated in dementia praecox, manic-depressive insanity and paranoidal states. Further research reveals now psychogenetic factors in many of the so-called alcoholic psychoses, in epilepsy, hallucinatory deliriums and prison psychoses. We understand now to some extent that the aim of these psychological mechanisms is constructive and that the patients thereby have defended themselves against internal warfare, have built a world of their own in which they feel they can live, and have in many instances obviated mental pain and self-reproach and gained their compensations.

In warfare we should not be surprised to find great opportunities for mental conflicts. The battle within between the highest desire to follow the dictates of duty and honour, and the individualistic wish for safety and to be out of it all, is a conflict that must occur at any rate now and again to almost every combatant. News from home of a disturbing nature, the separation of loved ones and the unfaithfulness of wives cause worries that one hears of in case after case of mental trouble.

Exhaustion and indisposition, rendering the sufferer less able to work properly, tends to bring about morbid feelings of incompetency, unworthiness and impotency. Enforced sexual abstinence in some, causes anxiety; promiscuous intercourse, self-reproach, and I believe that the sole male communionship in many, lights up a latent homosexuality which, though perhaps never becoming conscious, produces a mental conflict and, may be, a paranoidal state. Of course mental conflicts can produce no psychosis if resolution takes place normally, but through repression and abnormal resolution, havoc may be wrought and especially in those whose mental soil is fertile.

I am convinced that in a large number of instances alcohol is freely taken to narcotize these conflicts which might or might not have produced psychopatic symptoms without its use. As I have stated before, even in those abnormal states which follow upon physical illness, trauma or exhaustion, there is good reason for believing that a psychogenetic factor is present and brought to the fore by a failure of repression caused by the temporary loss of inhibition. Let us pass on to consider some points of the various mental reactions we find in the war psychoses.

At "D" Block, Netley, which is only a Clearing Hospital, every expeditionary force officer, N. C. O. and soldier from every theatre

of war, France, Belgium, Italy, Salonica, Egypt, Mesopotamia and Palestine is admitted, examined and then sent on with a full report of his case to one or other of the British Mental War Hospitals where he remains, if necessary, for nine months before being certified as of unsound mind and placed in an asylum as a special service patient. Since the outbreak of war a large number of officers and men have been admitted. Of these men about 60 per cent had been under fire and about 40 per cent had not been under fire. A certain proportion had previously been inmates of Asylums. The average length of stay of each case in this hospital is only a few days, so that any deep study of the individual cases has been out of the question; but what one has lacked in this respect is to some extent compensated for by the large numbers and wide though superficial outlook gained.

I have made statistical notes on 3,000 consecutive cases whose clinical careers I have followed up. Later I shall publish my findings and deductions therefrom. In this present short survey I purport only to make a few remarks under the headings mainly of reaction types. It is a futile proceeding to endeavour to fit each case into some text-book type. That only leads to much scientific inaccuracy, for few observers would agree in so many instances as to what particular label should be tacked on. Greater knowledge leads to improved diagnosis and greater difficulty in labelling. Officially, all cases must be returned according to a hard and fast nomenclature full of errors. This unfortunately will render official statistics practically valueless.

Perhaps the first thing that would strike the average observer if he saw a collection of mental cases from overseas would be, I think, the outward and visible signs of general *mental deficiency* as depicted upon the faces he saw before him. Though facial expression and features are but poor and superficial guides in this direction, in the main, he would be right in his assumption that a very large proportion of the men had a subnormal mentality. It is true that the expression of those who are confused and apathetic tends to lend the countenance an appearance which is deceptive. It is surprising how, when the confusion disappears and more interest is taken in the environment, the previous impression of intellectual defect vanishes at the same time.

I am inclined to think that the question of mental deficiency—using the term in a wide and scientific sense—is one of the most important with which the recruiting authorities have to deal.

When my statistical studies are published, this point will be seen very definitely. Yet there are many issues connected with it which at first may not be thought of. It is astonishing to note the length of service of some of these men who arrive home with reports of their uselessness and their having been a danger to themselves and others. But on tracing their history one finds that so many were never permitted to use a rifle and for a long period of time had only been performing menial duties and had only perhaps broken down when the slightest responsibilities were given them. The difficulties of invaliding a man home under the heading "mental deficiency" may be, too, a reason for their remaining in service so long. A large number of such men are incorporated in the Labour Battalions, where it is presumed that a mental defect is of small account. We here see the idea carried out that if a man can do any work in civil life he can do it in the army, and can do it overseas. Unfortunately though, practice does not bear out any such theory as any psychopathologist would have predicted. Poor-witted farm labourers who have lived in the most simple surroundings all their lives cannot adapt themselves for long in an army organization and still less so when having to work under shell fire. With the games their comrades play upon them and the stern treatment meted out to them by their N. C. O.'s, is it any wonder that they develop some confusional symptoms, that they get persecutory ideas (which often have some true basis), and show stuporous and other psychopathic states?

Mental adaptability is something that one cannot weigh in a balance, measure in mathematical terms, or predict with certainty. How hard it is to prognosticate on such a question is shown by the surprising number of mental defects who *do* somehow or other adapt themselves normally for a surprisingly long time. One can therefore have some sympathy with the military authorities if they take up the attitude that they require the services of every available man, that no one can say with any certainty how long a certain type of mental defect may be useful and that it is worth their while to risk recruiting a man on the chance of his being able to serve for some fair period of time.

The psychiatrist sees only one side of the picture and it is possible that perhaps he takes a too academic point of view. Nevertheless one would be fair in saying that recruiting authorities are far too careless generally in this and in their attitude

towards the neuro-psychic constitution of the men brought before them. One must bear in mind that this has an important bearing on the swelling of the already enormous pension list which might have been to some extent obviated.

Many of the cases are found to be purely mental defects from fairly low grades to morons, while many others on this basis have superimposed symptoms. Some amount of confusion with memory defect is perhaps the commonest type met with, but transient excitements, depressions and delusional states are met with as well. Dementia praecox may complicate the clinical picture; while temporary paranoidal symptoms are very apt to colour any abnormal state that may be manifested. It would serve no useful purpose to go in to any further detail here of the psychotic conditions found. The medico-legal side of the defect is of importance. As may easily be imagined, these individuals are fruitlessly and constantly punished for minor delinquencies and only later are found to be, at any rate, partly irresponsible.

The various types of mental reaction may be considered under the headings of confusional, depressive, excited, paranoid and anomalous mixed types.

The Confusional States are extremely common, and it is because of this fact that it has been superficially supposed that some exhaustive factor must be the causative agent. Unfortunately the opportunity I had of studying my cases was so meagre because of their short stay at Netley that I should not like to express any definite opinion as to their pathology. The types met with vary so much that classification becomes difficult if not impossible, and certainly the majority do not conform to any text-book description. A certain number of cases are patently due to toxic influence and follow upon definite bodily illness. As I have already mentioned, the malarial poison was a common offender, and every convoy from the Eastern sphere of war contained some patients suffering from a mild confusion with which frequently a more or less severe amnesia was shown. These usually had been acute or sub-acute at the onset and had become somewhat chronic. A few presented themselves in almost stuporous conditions. The acute confusional states differed in no way from those seen in civil life but, without a definite causal history, it was impossible to say whether the case would prove to be one of dementia praecox when the acute onset had subsided. More or less acute hallucinatory states were brought about more especially after psychic

shocks and presented the symptoms of an acute hysterical dissociation which were generally only of quite a temporary nature. Traumatic cases such as the concussional, showed nothing special, but, as with nearly all psychotic symptoms, there would be a war colouring to the picture. We may truly say that the various types of confusion are often wrapt in obscurity as regards their pathology, and the war literature up to the present hardly throws any light on the subject. Mallet,[23] devotes an article on it, but his findings do not lead us far. Charon,[24] states that there was no astonishment at the different varieties of confusion seen in war patients because of the prevalence of the alcoholic factor. This point has been dealt with before and more than seriously called in question, at any rate where British troops are concerned. Toxic factors are probably accountable for many cases, but what these toxins may be is by no means often obvious. Many confusions are undoubtedly purely psychological in origin such as those we see so commonly associated with mental deficiency. Maladaptable mentalities when called upon more or less suddenly to face difficult and new situations will naturally react in a confusional way from conflict of impulse. At times what is taken for confusion is really a dream state resulting from an inherent desire to negate reality.

Dementia praecox as might be supposed, accounts for a very large number of the psychoses of war. It is often impossible to be certain that this condition exists, until prolonged observation has taken place, as so many other of the mental reactions of war are akin to it. One sees so many cases in which there is marked apathy as a leading symptom that, in the absence of other diagnostic factors, time often alone can be the test and especially is this so as the previous history of the patient is so frequently not obtainable. I have constantly been deceived in this way and other psychiatrists have had a similar experience. The different types—hebephrenic, catatonic and paranoid—have been met with as in civil practice. Nothing special can be said of these, but naturally the context of their delusions and hallucinations has often a military colouring.

It is easy to understand that *the depressive reactions* would be more in evidence than excited reactions since all the circumstances of the soldier's life would naturally bend more in this direction. The loss or diminution of the herd instinct must arise at times when the individual feelings come to the fore and introspection

comes about with its morbid tendencies. Home worry is, one finds, a prevalent factor in the engendering of a mental breakdown even in those who previously had shown no psychopathic characteristics. The constant stern demands of duty, though hearts are sore and souls be in pain, must produce mental conflicts difficult of rational adjustment. As the emotions so largely in such an environment must be repressed, is it any wonder that many develop morbid symptoms? Depressive anxiety and morbid apprehension are seen in the milder cases and intense depression in the more severe. The feeling of diffuse anxiety and that some unknown harm is going to arise is so frequently met with that Lepine makes a definite class of these cases under the term, "anxious insanity" which he thinks more fitly describes them than melancholia. As in manic-depressive states generally, self-accusation and the symptoms of a morbid conscience are frequently in evidence, and not seldom can they be traced to auto-erotic associations upon which we know their pathology depends. It is an interesting and debatable point as to whether many of the anxiety conditions may not be due to ungratified sexual desire. One sees no reason why this should not be in some an etiological factor especially at times when inaction prevents the sidetracking of the energy. A very large number of depressions are only secondary to paranoid ideas. Some psychiatrists would not hesitate to place such cases in the manic-depressive group while others, including myself, regard the paranoid reaction as essentially primary and the depression only a natural sequence. This will be referred to later when I speak of paranoid cases. On the whole I find that the more typical forms of the depressive phase of manic-depressive insanity is not anything like as commonly met with among the war psychoses as one would expect. Because of the difficulties of exact classification and the differences of opinion on this point by psychiatrists, widely varying statistical results appear. The only British statistics published at present are those by Hotchkis,[25] who out of his 942 cases gives 133 as conforming to the depressive phase of manic-depressive insanity, i. e., about 14 per cent.

The excited reactions are comparatively infrequent compared with the other types. Hotchkis, out of his 942 returned only 31 as showing the manic phase of manic-depressive insanity. The manic cases, the acute confusional and the excited onset of a dementia praecox comprise the bulk of this type which calls for no special mention.

If I were asked whether there was anything special to note about war mental reactions I should unhesitatingly reply that a marked feature was the great prevalence of a *paranoid* trend. It seems to permeate into the clinical picture of a very large percentage of cases even where the outstanding features are widely different. It tends to colour the mental defect and the manic-depressive types, while in the dementia praecox case it is as usual a prominent early symptom, and is seen in full bloom constantly in a temporary acute pure paranoid psychosis. It may be that only a vague feeling of suspicion may be present or an indefinite sense that everybody is against them or it may develop still further into a definite brief unsystematized persecutory state. From my experience I would say that the soldier's environment and experiences tend largely to bring about this type of reaction. The psychological mechanism of projection is common enough in everyday life but seems to be brought into use as a defense reaction much more when under service conditions. The mental defect often has substantial ground for his persecutory ideas. He is bullied, made game of and tends to lead an existence which brings about the natural conclusion that everybody is against him. The whole trend of iron discipline fosters in some the idea of persecution which becomes exaggerated in a mind that is morbidly disposed and that has become individualistic. When duties are not performed satisfactorily the "bad workman blames his tools"; the soldier may take up a similar attitude. Morbid introspection leads to the arousing of old self-reproaches, conscious and unconscious, the resulting conflict ending in projection.

The history of a typical case is that the man is seen to become asocial and to avoid his comrades, to become depressed and to sleep badly. Casual remarks elicit the fact that he thinks everyone is against him and after a time he becomes persecuted by a definite group. He imagines he is regarded as a spy and an object of suspicion by every one. Hallucinations may or may not further complicate the picture. If they develop, the "voices" threaten to "do him in," to call him filthy and obscene names, and to accuse him of the most immoral acts. This condition of an acute hallucinatory paranoia is a marked war psychosis. In many instances alcohol enters into the history, and these states are usually regarded as alcoholic; but precisely the same syndrome is produced without the drug. I regard alcohol only as a side issue, aiding mental regression, helping to remove inhibitions and

thus perhaps more fully precipitating the symptoms. It is often easy to see that it was because of the mental conflict that the alcohol was taken as a refuge and narcotic. These cases have a good prognosis and often recover within a few weeks with insight. The pathology of these cases requires much more elucidation. Freud and his school state that homosexuality is a basic factor in paranoid states. It certainly must be patent to any observer that sexual matters enter very largely into the hallucinatory content of these patients. Considering that this kind of psychopathic reaction is so common on active service, it would be suggestive to investigate the theory that the herding of men together in the army where heterosexual intercourse is mostly excluded, tends to arouse a latent homosexual trend against which the personality defends itself by "projection." That this hypothesis has some grounds for belief is not improbable. As Mr. A. F. Shand[24] truly points out, suspicion is an emotion which though so prevalent, has been curiously overlooked and neglected by psychologists in the past. There is here much interesting material for investigation in war psychiatric work and I shall look forward to see later what the American neuropsychiatrists have to say on the subject.

The more psychiatrists see of *general paresis*, the more they find that the diagnosis depends upon a study of the combination of the mental symptoms and the organic nervous signs, plus the blood and serological findings. In my Clearing Hospital it has not therefore been possible to be by any means sure of how many cases were passing through our hands. Superficially one found that one had made many wrong conjectures when the cases were afterwards followed up. It is a very debatable point whether the stress and strain of war does or does not tend to be a factor in hastening the advent of this disease. Authorities differ very much in their statements, some denying that active service has made any difference while others take precisely the opposite view. It is, of course a very difficult point to decide. Having not yet classified my 3,000 cases, I am not yet in a position to make any statements in this regard, but I have certainly been struck by the incidence of the disease at a very much earlier age than one usually sees in civil life and by the very short period existing between the contraction of syphilis and the commencement of paretic symptoms. In the Russo-Japanese War the percentage was 5.6 per cent. Hotchkis,[25] in his analysis finds only two per

cent, and definitely states that the data on these cases do not justify an opinion on the part played by military service in bringing on the disease in the syphilitic.

Anomalous and mixed reactions of various kinds were met with which defied any definite scientific classification and a few psychoses resulting from gross brain lesions cropped up now and again. Though a fair number of epileptics were returned from the front, the number of epileptic psychoses were quite conspicuous by their absence. Epileptic confusion of a temporary nature was the main symptom seen. Many transferred home as cases of epilepsy were found on investigation to be really psychoneurotic in origin. It is curious to note that in the Russo-Japanese War epileptic psychoses were said to be as high as 22.5 per cent.

The so-called *alcoholic psychoses* have been mainly spoken of elsewhere. All one can say is that in many of the paranoid states an alcoholic history was obtainable and ordinarily these are classed under this heading. I do not think this is scientifically correct. Many modern psychiatrists are taking this view and regarding alcohol as an etiological factor in the production of insanity as overrated, incidence being confused with cause. The old text-book type,—alcoholic hallucinosis—requires its pathology remodeled. Important psychic factors are always present. Alcohol is not a necessary factor in the production of the psychosis, and usually the sensorium is clear and no definite toxic symptoms are observed. The acute intoxications, chronic demented states and Korsakow's syndrome stand in quite a different category. The question is ably discussed by Schneider [27], who quite endorses my views on the subject. One is tempted to pursue this highly interesting question further, but space forbids. Only a few acute alcoholic cases passed through my hands.

I would like before concluding to say a few words on *suicide* as met with under active service conditions. It is usually stated that different individuals tend to choose the means of suicide according to their occupation. Certainly there are excellent grounds for presuming that definite psychic factors aid in this choice and that mental analysis would often reveal the reason why drowning, poison, etc., specially appealed to the individual as a means of taking his own life. It is therefore an interesting point that the vast majority of soldiers use the razor for this purpose instead of the rifle which one would superficially suppose as the handiest weapon. I do not think either that the mechanical

difficulties involved in using the firearm is sufficient to explain why it is so seldom chosen. The majority of suicides that have occurred have been among the acutely hallucinated paranoiacs, who, driven to desperation through the continuous accusing "voices" sought an end to their existence. There were comparatively few suicides among the pure manic-depressive or dementia praecox cases. This, I think, is partly accounted for by the fact that the latter cases were of slower development and so came under special observation and supervision earlier. A few suicides occurred in quite temporary confusional states and where one could trace no previous depression or find evidence of mental conflict. Among the paranoid cases the act was very often premeditated, but amnesia for the act itself and shortly afterwards was extremely frequent. Such memory gaps are common enough when certain antisocial acts are performed and they become necessarily of great medico-legal interest. The genuineness of the amnesia is by many called in question. I recollect being told that an eminent alienist, when called in by the Crown to decide the question of responsibility in murder cases and where amnesia was said to exist for the act, said he did not believe in those losses of memory and he decided the question by always having the victim hanged! Personally, I believe that a true amnesia often does exist, though doubtless the memory could be recovered by special means. The conscious personality itself would tend to inhibit the act, so that for the time dissociation takes place as the result of the mental conflict and the suicidal act is performed while in this dissociated state. It has the same pathological basis as the amnesic fugue. Suicide mainly involves the absolute negation of reality. It is the furthermost limit of that flight from reality, which to some degree or other is perhaps the most fundamental human trend. The psychology of suicide requires much studying. Most psychiatrists only take it at its surface value. Wholey[28] has made some highly interesting observations on this subject and especially as related to the alcoholic. In the article referred to he says, "The regularity with which we find the alcoholic attempting suicide by throat laceration lends confirmation to the theory that a 'birth phantasy' determines the manner of suicide. Such an interpretation of the psychology of the alcoholic is in keeping with the theory of his homosexual fixation. . . . It is to be noted that it is not the affect-depression of the melancholic which drives these patients to sui-

cide but an overwhelming urge to escape from an imminent death attended by the most hideous torture and mutilation. . . . The alcoholic's 'torture' practically always includes mutilation of the genital organs." These ideas are extremely suggestive and mark a distinct advance in our conception of the pathology of suicide.

In conclusion, I would only draw attention to the lesson to be learned from psychiatric war work, that early recognition and treatment of mental disease brings about incalculable good. Under service conditions the soldier's abnormalities are quickly observed, with the result that he soon becomes placed in the best environment for his speedy recovery. The percentage of recoveries with us has been large. I hope that in the near future we may in England be able to adopt some such mental hygiene movement as exists in the United States. At any rate neuropsychiatry has a more hopeful outlook both for physican and patient.

REFERENCES

1. Freud, Sigmund. Origin and Development of Psychoanalysis; Five Lectures at Clark University, Sept. 1909. American Journal of Psychology, v. 21, p. 181–218, April 1910.
2. Jones, Ernest. Paper before the Psychiatric Section of the Royal Society of Medicine, April 9, 1918.
3. Mott, F. W. Shell Shock. Proceedings of Royal Society of Medicine, Feb. 1916.
4. Eder, M. D. War Shock. Lond.: Heinemann, 1917. 154 p.
5. Myers, C. S. Contributions to the Study of Shell Shock, I–IV. Lancet, Lond., Feb. 13, 1915, p. 316–20; Jan. 8, 1916, p. 65–69; March 18, 1916, p. 608–13; Sept. 9, 1916, p. 461–67; also except I in Journal of Royal Army Medical Corps, v. 26, p. 642–55, May 1916; p. 782–97, June 1916; v. 27, p. 561–82, Nov. 1916.
6. Hurst, A. F. Medical Diseases of the War. Lond., Arnold, 1917. 151 p.
7. Farrar, C. B. War and Neurosis, with Some Observations of the Canadian Expeditionary Force. American Journal of Insanity, v. 73, p. 693–719, April 1917.
8. Babinski, Jules, and Froment, Jules. Hysteria or Pithiatism, and Reflex Nervous Disorders in the Neurology of War. Lond. Univ. Press, 1918. 311 p. (Military Medical Manuals.)
9. Roussy, Gustave, and Lhermitte, Jean. The Psychoneuroses of War. Lond. Univ. Press, 1918. 191 p. (Military Medical Manuals.)

10. MacCurdy, J. T. War Neuroses. Psychiatric Bulletin, v. 2, p. 243–354, July 1917.
11. Yealland, L. R. Hysterical Disorders of War. 1918.
12. Collie, Sir John. Management of War Neuroses and Allied Disorders in the Army. Mental Hygiene, v. 2, p. 1–18, Jan. 1918.
13. Jones, Ernest. Treatment of the Neuroses, Including the Psychoneuroses. In Modern Treatment of Nervous and Mental Diseases, etc. Phil., Lea & Febiger, 1913. v. 1, p. 331–416.
14. Hall, G. Stanley. Synthetic Genetic Study of Fear. American Journal of Psychology, v. 25, p. 149–200, 321–92, April and July 1914.
15. Cannon, W. B. Bodily Changes in Pain, Hunger, Fear and Rage. N. Y.: D. Appleton, 1915. 311 p.
16. Jones, Ernest. Mechanisms of a Severe Briquet Attack as Contrasted with that of Psychasthenic Fits. 1917.
17. Hoche, A. Die differential Diagnose zwischen Epilepsie und Hysterie. Berlin, Hirschwald, 1902. p. 18.
18. Binswanger, Otto. Die Hysterie. Nothnagel's Spec. Path. u. Ther., v. 12, pt. 1. Vienna, Holder, 1904.
19. Lepine, Jean. Troubles Mentaux de la Guerre. Paris, Masson, 1917. 203 p.
20. Richards, R. L. Mental and Nervous Diseases in the Russo Japanese War. Military Surgeon, v. 26, p. 177–93, Feb. 1910.
21. Bonhöffer, K. War Experiences on the Etiology of Psychopathic States. Allgem. Zeitschr. f. Psych. Ref. Zeitschr. f. d. ges. Neurol. u. Psych. Ref., v. 13, no. 3, 1916.
22. Ferenczi, Sándor. Contributions to Psychoanalysis. Bost.: Badger, 1916. 288 p.
23. Mallet, Raymond. Etats Confusionnels et Anxieux chez le Combattant. Annales Médico-Psychologiques, v. 8, p. 27–35, Jan. 1917.
24. Charon, René. Psychopathologie de Guerre. Progrès Médical, v. 30, p. 425–28, June 1915.
25. Hotchkis, R. D. Renfrew District Asylum as a War Hospital for Mental Invalids. Journal of Mental Science, Lond., v. 63, p. 238–49, April 1917.
26. Shand, A. F. Paper on Suspicion. British Psychological Society, 1917.
27. Schneider, C. von A. Studies on Alcoholic Hallucinoses. Psychiatric Bulletin, v. 9, p. 3–25, Jan. 1916.
28. Wholey, C. C. Revelations of the Unconscious in a Toxic (Alcoholic) Psychosis. American Journal of Insanity, v. 71, p. 437–47, Jan. 1918.

MENTAL HYGIENE AND SOCIAL WORK: NOTES ON A COURSE IN SOCIAL PSYCHIATRY FOR SOCIAL WORKERS

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PATHOLOGY is older than sociology, and medicine, i. e., applied pathology, has more triumphs in its history than has social work, i. e., applied sociology. Mental hygiene, a branch of applied pathology, is naturally dominated by physicians and by a special group of physicians, viz., psychiatrists. But is there a co-ordinate branch of applied sociology? Does the medical branch of applied sociology have a subdivision deserving the name psychiatric social work? Or, put pragmatically, is there a group of psychiatric social workers who have control of a field of "psychiatric social work" co-ordinate with "mental hygiene"?

The comparative youth of sociology, of applied sociology (social work[1]), of applied medical sociology (medical social work[2]), and of the putative new branch (psychiatric social work[3],[4]) entails a certain fluidity of nomenclature at first not unserviceable. Nor would it be necessary or even desirable to fix at the outset a nomenclature for logical compartments of an undeveloped art, as we might thus condemn the art to stasis or bad *culs-de-sac*. I raise the question, therefore, only on the practical ground of whether or no specialists, professional or technical, have been developed or are in course of development in this field of sociology. For, if so, that is, if the new art has found its shoulder-to-shoulder workers, then it is high time to state the principles of their alignment, and the nature of curricula and practical experience necessary for these workers.

I assume that medicine and applied sociology are professions with their professors and practitioners having due recognition in university degrees, M.D. and Ph.D., respectively, and in commonly accepted titles, *physician* and *sociologist*. On account of the recency of sociology's foundation, everybody is prepared to accord to many workers without the degree Ph.D. just as good and perfectly equivalent dignity. Nor should such a contention as that sociologists will more and more tend to be Ph.D. bearers

be regarded as propaganda of Professor James' "Ph.D. octopus," since everybody is now aware that novelty, in medicine, sociology, or any other branch, is perhaps more likely than not to come from some distant science. Thus the teaching branches of medicine are more likely to get novelty from e. g., chemistry, or physics, than from their own more limited fields. And the teaching branches of applied sociology are very likely to profit more from anthropology or psychology than from the recognized rounds of sociological research as narrowly conceived, e. g., in the field of social statistics. Perhaps even it might be said that many branches of didactic medicine and sociology would get more food for new thought from each other than each from itself. We are not here talking of the technique of research, but of the sort of training which allows us to concede that such and such a person is entitled to rank as a professional sociologist alongside the physician.

There are, to repeat, persons to whom we accord an equal professional rank as didactic or practical masters of their fields—physicians and sociologists. But every professor must develop apprentices or ancillary workers of various sorts. Thus medicine has developed the *nurse*. Applied sociology, I make bold to say, has developed quite on the same level—the *social worker*. One has to be bold! For many social workers, perfectly modest as to their own private capacities, have developed a surprising group-consciousness concerning the proper dominance of the ideal social worker in all social maladjustments. This group-consciousness of social workers often leads to a not unwarranted derision on the part of physicians, judges, men of the world. The point here is probably simple: just because not every eminent sociologist is a Ph.D. and because many sociologists prefer to call themselves "workers" (from the American habit of denouncing theory and suspecting all 'ologists of carrying lugs), many humbler persons conceive that there is no theory behind their practice, no sociology behind their social service. It is as if on the one hand, physicians seeing that medicine is so much a matter of nursing should announce themselves as a kind of nurse; it is as if, on the other hand, nurses seeing that the physicians are so ignorant of many practical matters should suddenly conceive that nurses were after all a sort of physician. Practically, too, in the present phase of social service development, social workers are apt to be of a finer grain and a more finished higher education than the

majority of nurses, and accordingly the social workers are inclined to develop a feeling of group-superiority to nurses. This attitude is of course a matter of dispute as to its justifiability, but is none the less existent. But I conceive that, unless a person wishes to go to the length of special training of professional grade, he can hardly claim equivalence to a man of professional training. I conceive that professionally trained social workers, of the Ph.D. level or equivalent, will finally admit themselves to be sociologists, albeit applied sociologists. And I hope that further there will be a group-consciousness developed of social workers below the 'ologist grade with an attitude resembling that of nurses to their work—an attitude, according to temperament, of humble pride or proud humility with respect to their acknowledged leaders. Nor should the term *profession*[5] be made a stumbling-block: if nursing is a profession, so ought social work (below the level of sociology) to be acknowledged a profession also; but this last is a matter of terms only.

We thus obtain the following comparisons:

Pathology	Sociology
Medicine (i. e., applied or practical pathology)	Applied or Practical Sociology
Degree: M.D.	Degree: Ph.D.—or equivalent experience
Practitioner: physician	Practitioner: applied sociologist (more modest titles or special titles usually assumed)
Auxiliary: trained nurse	Auxiliary: trained social worker

Up to this point, I think, all will agree who have looked into the facts of actual progress in the two fields. Considering the relative novelty of sociology, we can only regard it as very striking that the practical social worker has so soon taken her high place in the world alongside the nurse.

But no two sciences or arts can in these days long exist without fruitful contacts. Pathological and sociological progress have gone hand in hand. Many a physician is, we say, really and by temper a sociologist; many a sociologist develops so deep an interest in, e. g., sanitation problems that he becomes in effect a physician, at least an expert in public health. Social medicine and medical sociology have much in common: either could receive the term *theory of the public health* without special error of definition.

Not to linger over the definition of public health, hygiene, and preventive medicine as against the non-medical branches of sani-

tary science and art, it is clear that both social medicine and medical sociology have brought to life auxiliary groups of practical workers, viz., the *public health nurse*[6] and the *medical social worker*. It is clear, too, that, just as social medicine and medical sociology are different in their points of view, so the aides in the practical work of each field are likely to have a different point of view. If the lively growth of the public health nurse group sometimes threatens to engulf the medical social worker (e. g., by proposals that the same curriculum will do for both), the fact is that no such forced union will ever take place, judging by the quality and nature of the persons each field has so far attracted.

Assuming certain differences between the public health nurse and the medical social worker, I want to press to another inquiry, whether the art of mental hygiene, taken either as part of medicine or as part of sociology, has the right to think of establishing its own auxiliaries, i. e., by a kind of differentiation of nurses on the one hand and of medical social workers on the other.

Now it is obvious that the public health nurse of today is no better prepared to be an aide to a psychiatrist than the ordinary physician is trained to deal with psychopathic cases. Should there not be a new group of nurse-like human beings who should be aides to psychiatrists in much the same sense as public health nurses are aides to the public health physicians? On the other hand, should not there be a special group of medical social workers skilled in the psychiatric side of medical sociology? Or will, perchance, these two kinds of auxiliary be identical, both as to the timber we choose to develop and as to the curriculum we lay down?

Another parallel column array may clarify the issue:

Physician, M.D.	Sociologist, Ph.D. (*et al.*)
Trained nurse	Trained social worker
Public health nurse	Medical social worker
Psychiatric nurse	Psychiatric social worker

The point raised is whether either or both of these last-mentioned auxiliaries should be developed and, if something of the sort is desirable, whether the training of these mental hygiene aides ought to be specially conceived *in re* curriculum and experience.

Every psychiatrist, nay every man of the world, is familiar with nurses and social workers (even medical social workers) who would manifestly *not* do either as trained aides in mental

hygiene or as timber for such. On the other hand, everybody knows a few persons, whether nurses, social workers, or just human beings, who admirably fill special requirements in the mental hygiene of some situation or would probably soon become fitted for such work. We think of sympathy and firmness, adaptability and steadfastness, quick insight and profound commonsense, modesty and knowledge of the world, and always and forever tact without prevarication, as desirable qualities for these persons. People in general ought to have these qualities too; but we want them more intensively still for our proposed mental hygiene aides. How wonderful, we opine, would it be if we could only reproduce by the scores and hundreds that particular nurse, social worker, clinic manager, companion, usher, secretary, clerk, psychological assistant, probation officer! Oh, if the world were better stocked with persons of such understanding! Alas! we are inclined to believe, the real mental hygiene aide *nascitur, non fit.*

I have recently given two sets of lectures to social workers on what I termed social psychiatry. They were given at the instance of the School of Social Work in Boston and the topics were chosen, in consultation with Miss Lucy Wright, Associate Director of the School, which is a department of a college for women, Simmons College. These lectures are my excuse for a psychiatrist's taking a few plantigrade steps in the garden of social work.

In the parallel columns above we found ourselves endeavoring to contrast at every turn the work of the physician and his aides and the work of the sociologist and his aides. Yet when we came down to the practical question—whether there might be developed a special group of lay aides and advisers in mental hygiene—we found ourselves reduced to acknowledge that perhaps these persons are born, not made.

All through the preparation for lectures on social psychiatry and especially in the discussions themselves, sundry rather profound differences in point of view seemed to stand out in relief, making it appear as if the trained social worker would not as such readily grasp the point of view of the mental hygiene aide. I have placed some of these differences or tendencies to difference in parallel columns.

Mental Hygiene (taken as a department of medicine)	*Social Work* (taken as a department of sociology)
Primary aim: aid of individual	Primary aim: aid of community
Tends to sacrifice community for individual	Tends to sacrifice individual for community
Tends to sacrifice family for individual	Tends to sacrifice individual for family
Hesitates to place patient in an institution	Overreadily suggests placing patient in an institution
Overoptimistic for the individual, overpessimistic for the community	Overoptimistic for the community, overpessimistic for the individual
Underrates effect of environment upon patient	Overrates effect of environment upon patient
Overanalytic and apt to consider task done with analysis	Oversynthetic and apt to rush into premature conclusions
Has little confidence in legislation as panacea	Loves to devise stiff legislation

But is it wholly fair thus to parallel mental hygiene and social work? For above, did we not contrast social work (that is, applied or practical sociology) with medicine (that is, applied or practical pathology)? We did not co-ordinate social service with mental hygiene as divisions of study and practice on the same level. Might it not be that social work, though its primary aim is the aid of the community, will find somewhere within its scope sufficient play for the individual's advantage also? Though social service tends or seems to tend to sacrifice the individual for the community, may it not be that somewhere within the scope of applied sociology the individual will be rescued? May it not prove possible to aid the community without sacrificing the individual, at least the so-called normal individual? In brief, by isolating mental hygiene as a subordinate department of medicine, have we not at the same time narrowed our issue so far, for the purpose of bringing the individual into the centre of the stage, that a wholly artificial contrast and distinction has been set up between mental hygiene and social service?

We shall in the sequel, I think, become certain that the practical aims of mental hygiene and of social work are largely identical. Yet it appears to me that they will always remain not wholly identical. It appears to me that the claims of the individual as such are not only logically, but also psychologically and practically, distinct from the claims of the community. In short, I think it will be possible to show that the point of view of medicine and the point of view of social work are at bottom sundered from each other, so that the physician and the sociologist, the nurse and the social worker, the mental hygiene aide and the psychiatric social worker, will always remain persons with somewhat separate sen-

timents. It is worth while to insist that these sentiments though separate are not necessarily opposed to one another. It is even possible that within a single personality a worker can be an effective individualist, on the one hand, and an effective social-groupist, on the other; that one can be both a physician and an applied sociologist successfully; but the success attained will probably be like that in which the right (or medical) hand, will not know what the left (or social) hand, is doing. It is my belief, though this is not the place to expound such, that the entire point of view of medicine is at bottom individualistic, though mental hygiene taken as a subordinate department of medicine is even a little less individualistic than the rest of medicine. I feel that, theoretically at least, the physician is often ready to sacrifice both the community and the family for the sake of saving, prolonging, or sweetening the life of the patient. It is my judgment, also, that the majority of physicians will be found holding most of the points of view listed in the column under mental hygiene above.

One cannot help noting, as above mentioned, that mental hygiene is on the whole a little less individualistic than the rest of medicine, and that, by the same token, the medical branch of social service, and especially the psychiatric subdivision thereof, is a branch of social work in which the individual's advantage stands out a good deal more than in social work at large. The unit of interest for the physician is the patient; the unit of interest for the social worker is the family. The unit of interest of the mental hygienist remains primarily the individual patient, but on account of the important public and social relations in which the individual patient stands, the mental hygienist must perforce see the patient in the midst of an entourage. The mental hygienist must confront, even more than the physician at large, that somewhat mysterious entity known to the older sociologists as the *Socius*. Per contra, the psychiatric social worker is apt to forget the community somewhat, to forget the milieu, and to see the small entourage of the patient's family dominated by the psychopathic figure in its midst. Now, whether you come at the situation as a mental hygienist and see the psychopath only a little more clearly than his entourage, or whether you come at the situation as a psychiatric social worker and see the entourage only a little more clearly than its contained psychopath, amounts to a pretty tenuous distinction, at all events when it comes to action. The mental hygienist has left behind the merely medical

matter of diagnosis, prognosis, and treatment of this particular case shelled out of the family group, and the psychiatric social worker has almost, if not quite, forgotten that such a unit as a community exists. In short, it is almost all one whether the mental hygienist takes the psychopath as his unit of interest, and the psychiatric social worker the family as the unit of interest. The real point lodges in the relation between the psychopathic figure and the other figures in the family entourage. At this level of discussion, the mental hygienist would scoff at the thought that he tended to sacrifice family interests to individual interests, and the psychiatric social worker would alike deride the notion that the individual's interests were being sacrificed for those of the family. Time was when I should have thought the drawing of this distinction superfluous and the idea depicted a truism. However, in the course for social workers which gave rise to these notes, I found that the differentiation of these two points of view was a very live issue; and upon turning to sundry works upon sociology and community work, I am only strengthened in the conclusion that clarity upon this point—as to the actual unit of interest in sociology—is not readily achieved. It does not do to say that the distinction is licked up and vanishes in a higher unity; for that higher unity invariably turns in most modern books on sociology into the community. In any case, whatever the ultimate truth, it is important for the social worker to get at the point of view of the physician for the sake of mutual, practical understanding.

Many card-catalogues in social agencies employ the family as their unit, the family being as a rule an entity which is somehow economically at fault. But when it comes to medical social service, and especially to psychiatric social service, I am inclined to think that the card-catalogue unit ought to be the patient and not the family.

The first of the two sets of lectures to social workers was given to a selected group of advanced workers, who engaged in more or less free discussion as to the distinctions just drawn. I am not sure whether the existence of a field of mental hygiene as distinct from that of psychiatric social work was conceded by all my hearers; but if the existence of two points of view and two angles of approach to the same mass of material was allowed, much I think was accomplished. At any rate, I think there was no doubt in the minds of the listeners, that a field of psychiatric social

service existed distinct from medical social service as a whole. I think it became plain that schools for social work or philanthropy, or under whatever name they may masquerade, should specialize their training for advanced workers more than has been customary in this matter of social psychiatry. Whatever doubt there may be as to the nomenclature of these fields, there can be no doubt, and especially in view of the social service hopes engendered by the war, that new tasks for expert propagandists are popping up on every side. In such a journal as MENTAL HYGIENE, the expert propagandists ought to exchange counsel and prepare for the popularization that must come in subsequent years. The war considerations permit us to take up a good deal of slack in the program; for in the war stress, nothing flaps and dangles as it seemed to do a few years since. Anybody's nomenclatural suggestions are thrown at once into tense looms at Washington and, lo! "neuropsychiatry," "neuropsychiatric experts," "neuropsychiatric units," get born or at least christened. How long it might have taken without a war to tie clinical neurology and psychiatry together thus closely is impossible to say.

The term *mental hygiene* itself, one had to maintain with the social workers, was a good term. Even its apparent vices could be shown to be merely unevolved virtues. The term *hygiene* had of course been commandeered by the public health movement, which styled itself a movement for hygiene and preventive medicine; yet it was not at all clear that the term should have been commandeered for physical considerations only. To be sure, the hygienist of the epidemic-preventing and sanitary group is apt to have a feeling of confusion and impotence when confronted with the term *mental* hygiene. Ten to one, such a physical hygienist has never looked at the economics of even the insanity problem (that small corner of the whole field of mental hygiene); or, if he has looked thereat, the huge state costs of committable mental diseases, dwarfing the costs of the physical hygienist's own field, are likely to be dismissed with the thought that insanity belongs somewhere with death and taxes—a necessary evil and drag upon civilization, bound to remain at about the same level or even to increase and get beyond public control. The vision of preventive *mental* hygiene is hardly obtainable by the physical hygienist of the day.

There is, of course, one comfort in the neglect of mental hygiene by public health workers. The mental hygienists themselves

will have none to blame except themselves if their field is not cultivated aright. We remain in a horticultural and not an agricultural phase in mental hygiene as yet. Let us not develop a *hortus siccus* of

Leaflets for the Lazy
Blessed Don'ts for Blue Devils
Buried Memories and the Need of Careful Exhumation
Attitudes to Adopt toward New Ideas
Efficacy of Courtship under Medical Supervision
Can the Feebleminded Really Become Bankers?
Thomas Jefferson versus Alfred Binet
Something to be Said for the Bolsheviki.

Possibly these titles but remotely suggest the so-called "healthgrams" of the day, but I am sure that no mental hygienist is quite ready to institute a mental hygiene program consisting chiefly of punch.

In order practically to bring out the individualism of mental hygiene as contrasted with the family-groupism and community-groupism of social work, the technique adopted in the courses on social psychiatry here discussed was to demonstrate in skeleton form the histories of a number of intensively studied social service cases from the Psychopathic Hospital group. They were largely supplied from special studies by Miss Mary C. Jarrett, and a large minority of them had been published in various papers from the Psychopathic Hospital.[7-14] For the purpose of these courses, however, the cases were grouped and studied in different ways. In the first place, cases were analysed from the standpoint of a triple division of mental hygiene into public, social, and individual problem groups. I have discussed this tripartite division of mental hygiene in a previous paper,[15] and will here recall only that the distinction follows one of Dean Roscoe Pound in his chapters on sociological jurisprudence, drawn between the interests of organized government, on the one hand, as against unorganized community interests on the other, both being opposed to the interests of the individual. It was easy to show in the skeleton analysis of social service cases how public, social (in this narrow sense of non-governmental), and personal interests came into play. It was easy for the social worker, on logically separating out the public aspects of the case, to catch the point of view of the judge, the hospital administrator, and the legislator, and the immigration authorities, in certain instances. Again, in other in-

stances, by the pure process of separating the personal aspects of the case out from the social and public, it was quite possible to get an angle wholly different from the ordinary social worker's angle. It became easy to see how circumspect must be the management of a case with public aspects, how delicate that in a case with personal difficulties. The psychiatric social worker was thus taught to see what the mental hygienist starts with knowing, namely, that a large number of problems in social psychiatry cannot be left to the management of the social worker, since the heavy hand of organized government and administration, and the filigree psychic interior of many a personal situation interpose. The technique of handling judges, on the one side, and physicians, on the other, without prejudice and with due consideration of authority, can be simply taught by means of this tripartite distinction of the problems of social, psychiatric, and mental hygiene into public, social, and personal.

$$\text{Group} \left\{ \begin{array}{l} \text{Public} \\ \text{Social} \\ \text{Personal} \end{array} \right\} \text{Private}$$

Valuable as the tripartite distinction—public, social, and personal—often is, for other purposes we need to distinguish public from private (private including non-governmental social matters as well as personal ones), and we need to distinguish group matters from personal ones. The distinction "public versus private" has in applied sociology far less range than in jurisprudence; but the distinction between group and personal matters is in the forefront of most works on sociology. Works on ethics also are apt to deal nowadays with group ethics rather than with the ethics of the individual.

As mental hygienist, it was my duty in these lectures to lay more stress upon personality than upon the properties of the social group. It proved clarifying to recall to my hearers the truism of psychology, that every personality is itself in some sense a group. I used for the purpose the familiar distinction of the spiritual, material, and social—selves of William James—and used his grammatical distinction of the Ego and the Me. Leaving out the social self or social Me as a group concept, I pointed out the value of some distinctions, drawn by James in his famous chapter on the self, between the Ego and the material Me. The figure of speech, if it be such, which contemplates the material Me as now and then in control of the Ego, is particularly interest-

ing to the social worker, familiar with the concept of group ethics; and the metaphor of the personality at war with itself, if it be a metaphor, is becoming a familiar one with all the modern work on mental conflicts—the new branch that we may call psychomachology. When the approach is made to these penetralia of psychology, it becomes easy to insist that the obvious thing is not always the right thing to do in a psychopathic situation.

Social workers should not always rush in where psychiatrists fear to tread. This matter of the relations of the patient to himself (quite too simply dealt with in the metaphor of the Ego and the Me) I have expounded to a slight extent elsewhere.[16] The whole grammatical point of view is doubtless too simple to account for much of the whole problem. Still I found that the concept of the *passive voice* proved an interesting one to many workers. The social worker often confronts a family with a more or less psychopathic figure objectively dominant in the scene. I say objectively dominant because the disturbing figure himself may be from his own point of view a depressed person quite in the passive voice. He may be even a rather violent feature of the situation, and may objectively do many dangerous and destructive things; yet upon analysis of his psychic interior, the situation may prove one, for the psychopath himself, of the passive voice. This key to the psychopathic situation may be quite missed by the social worker, who judges only by the obvious violence and destructiveness of the man's actions. The caged lion is objectively active and letting loose a good many foot-pounds of energy, but he is nevertheless a lion caged, and from his own point of view in the passive voice. The proper therapy from the lion's point of view would not be to anesthetize but rather to uncage the lion. Again, the foil to this situation occurs when the psychopathic figure in the family situation is to all outward observation an inoffensive quietistic person—who however refuses to work! Such a man, though objectively inactive, is sometimes subjectively extremely active; he is so far as the family is concerned, playing 'possum as to work. He is not at all in the passive voice, from his own point of view, but is actively dominating his environment.

These suggestions must suffice to indicate the value of an analysis of psychic situations from the simple grammatical standpoint of the passive voice. It appears that many of the social service cases presented could get a very considerable illumination

from this source. Analysis of the individual in the light, say, of modern work on social psychology would demonstrate how every individual is, as it were, a group within himself, and how now one, now another, instinct would come to the fore.

Many of the skeleton social service histories were reviewed several times in the above and other connections. I will give one more instance of a scheme of analysis derived more from medicine than from sociology, but for all that, of some value. It can be objected that sociology too readily considers men as alike; too readily harbors such an idea as the Ricardian idea of the "economic man"; too readily entertains the thought that norms exist, and that the feebleminded and geniuses are merely low and high points on a smooth curve. Medicine at all events, though it endeavors to use the quantitative and statistical methods available, is more interested in qualitative differences, and may perhaps rather too readily find these in its material. Medicine looks more at what is lacking or has been lost, or is slanted and twisted out of shape, than at the low values of measurements. Medicine is one of those sciences that deal with evil as such. Sociology and ethics might very happily get on without much more evil than would serve as a condiment in a quantitative world. I uphold the possibly one-sided view that we should study evil in and for itself for the purpose of destroying it, or as much of it as possible, leaving the good and especially the millenniums and Utopias to take care of themselves. For this purpose, I made a tentative classification of the kingdom of evil as follows:

Disease
Ignorance
Vice
Crime
Poverty

Abstracting from other forms of evil, and so far as possible subsuming them under one of these five divisions, I inquired whether all the cases of social maladjustment did not relate with one or more of these great groups of evil. Whereas the tendency of the sociologist would be to consider poverty first as the arch cause of social maladjustment (the argument from the submerged tenth and the like), I felt that the first inquiry should be in all cases of social maladjustment, whether there was not somewhere in the situation a more or less *medical* scene. The figure in that scene might be an obviously sick, even a physically sick man; but, less

obviously, the medical figure might be psychopathic, and the defect might be so mild from the medical point of view that no one really suspected that the nucleus of the social maladjustment was really a psychic one.

But again, supposing all question of physical or mental disease or defect could be ruled out, might not the dominant feature in the scene be some form of error, due to lack of education and intellectual training? It is really a positive evil in certain circumstances not to know the mother tongue of the country in which one lives. But again supposing there is no bodily or mental disease and nothing attributable to poor education, there might be, thirdly, some vice or bad habit due to poor moral training or demoralizing experience. All these, and the fourth question of being in some difficulty on account of the breaking of a law or ordinance, or being in the hands of some financial stress or debt, or other engagement, would need to be placed ahead, according to my view, in many cases, of any consideration of poverty as a cause of the social maladjustment.

In brief, before deciding that a case of social maladjustment is one of poverty and resourcelessness to be solved by the familiar methods of poor relief, it appears to me desirable to consider the maladjustment in the light of several prior hypotheses, namely, the hypotheses of disease, ignorance, vice (including bad habits), and crime or delinquency. This classification of existent evils and this particular order of examining them, I used in analyzing sundry social service cases from the Psychopathic Hospital. I found, of course, that many instances yielded evils of maladjustment in every one of the five compartments, but in almost every case there was no practical doubt which of the five compartments was the most important. But whether or no these groups of evil are the final ones, whether there should be more or less, and whether the order of consideration should be altogether altered, must remain doubtful. It seems to me that in any event some simple classification of maladjustments which can be borne in mind in rapid every-day work, ought to be set up, and that experience will determine in what order the analysis of social maladjustment shall take place. Just what fraction of the world's social maladjustments can be safely assigned to mental disease and defect, no man can now say.

In Miss Richmond's valuable book on social diagnosis, I found that fully half the cases there cited to illustrate all manner of

general and technical contentions were cases with a strong psychopathic tinge; cases, in short, in which analysis would have found much to its purpose in compartment No. 1 of the kingdom of evil, namely, the disease compartment. If a collection of cases such as these of Miss Richmond's, chosen for quite another purpose, demonstrates so high a percentage of disease, and especially of mental disease, I think it is clear that a revamping of the whole attitude of social service to its problem may become necessary, and that social work in general will find itself far more medical than it ever formerly suspected; that medical social work will find itself far more psychiatric than any one had anticipated; and that psychiatric social work will find one of its chief aids in mental hygiene.

It would be possible to extend these "notes" greatly, and surely much must be said before the program of social psychiatry in its large outlines for social workers can be regarded as at all settled. Despite certain differences in point of view emphasized above between mental hygiene and social service, I feel that, in the war situation now confronting us, it is important for physicians and sociologists (or social workers, if the name please them more) to make common cause. I brought up the question at the outset, whether mental hygiene had the right to think of developing its own auxiliaries; that is, certain persons that might be called mental hygiene aides, who should stand to mental hygienists as public health nurses stand to the medical specialists in preventive medicine. I am inclined to think that, if such new class of mental hygiene aides were developed, the best source for them would be trained social workers. However, the trained social workers will probably be utilized quite to the full in various Red Cross and other fields. I think that teachers, librarians, psychological assistants, some specially selected nurses, and other persons having an equivalent training, particularly those having a collegiate degree, might be supposed to be the most promising candidates for such work. The chief argument for the A.B. degree is that it not only assures a certain maturity in years, but is rather apt to give the bearer some notion of the importance of language in any situation. Many of our problems are in persons without much English, and an appreciation of their difficulties is best had by persons who have had some sense of the difficulty of language learning.

I feel that a course for psychiatric social workers should be an advanced one, to follow after the lecture work in schools for social

workers, though the undergraduate work in these schools also should contain a certain amount of mental hygiene. The advanced course should contain surely a résumé of applied sociology and of the technique of social investigation, and these lectures and corresponding quizzes should be made thorough and inclusive for persons without extensive training in social work. There should secondly, be a résumé of social psychology, using such a work as MacDougall's *Social Psychology* as collateral reading, besides various sociological works that nowadays give the psychological point of view an appropriate attention. Thirdly, the general principles of neuropsychiatry (considered as an entity compounded of clinical neurology and psychiatry) should be presented, preferably with demonstrations of patients, and with due remembrance of laymen's difficulties in nomenclature.

The threads of sociology, social psychiatry, and neuropsychiatry, should then be gathered perhaps in lectures on mental hygiene, on the general field of mental hygiene and on its applications to sociology and psychiatry. The relations of psychiatric social workers to physicians, nurses, occupation workers, vocation workers, and others engaged in reconstruction, should be particularly emphasized in this war-time course, and care should be taken that the work in physical therapy and in handicraft teaching and invalid occupation, should be sympathetically understood by the psychiatric social workers, even if such physical and occupational work is not to be undertaken by them.

Supposing such a course to occupy three to six months, it might be possible for some twenty social cases to be worked with by each student under supervision during the time of the course, provided that the course is given in a centre where such cases are available and under control. Every psychiatric social worker should be familiar enough with mental tests to understand their applicability, value, and limitations. Some twenty mental tests should be performed under supervision during the lecture course. Meantime, the insane, the psychopathic, and the neurotic groups of patients should be seen by the psychiatric social workers so that the legal and medical points of view may be understood.

The courses on social psychiatry for social workers which have occasioned my writing these reflections, were naturally far from complete and only remotely touched several of the major branches here mentioned. In endeavoring to delimit the subject of social psychiatry and lay down its main points for lay social workers, I

concluded, however, that lectures for psychiatric social workers of value in the war would have to be at least as extensive and comprehensive as above sketched. That the majority of the war cases will be under military control of course both simplifies and complicates the social service problem, and the military point of view would probably need to be expounded in a separate division of the course.

Summary

Some reflections have been put together on a course for social workers on social psychiatry recently given in Boston. These reflections deal largely with some distinctions between mental hygiene and social service. Mental hygiene is regarded as a branch of medicine, in a sense co-ordinate with the psychiatric branch of social work.

At first, the distinctions between mental hygiene and psychiatric social work are very clearly and definitely drawn. Particular emphasis is laid upon the individualism of the point of view of mental hygiene as against the groupism of social workers; but in the end, it is pointed out that if mental hygienists are to obtain auxiliaries, such as every expert eventually obtains in the evolution of his art, these mental hygiene aides will probably be best drawn from the ranks of the social workers; they will be a kind of specialized and advanced social worker.

The point is that as the mental hygienist advances from the individual to the family and thence to the community, so the social worker, at first aiming at the community, focalizes upon the family, and finally gets a point of view concerning the individual not far from that entertained by the mental hygienist.

Despite the logical differences, then, between the point of view of mental hygiene and that of social work (logical differences which it is well to bring out when endeavoring to get the medical point of view to some extent over into the minds of the social workers), there will be in practice little doubt that mental hygienists will find some of their most valuable aides in specially trained social workers. Just as the orthopedists will use nurses and others skilled in physical therapy, and just as the vocation workers will use persons specially trained in invalid occupation and in handicraft teaching, so the mental hygienists in war time will crave the aid of specially trained social service auxiliaries; that is, mental hygiene aides that have been given special training.

In the Boston course, largely for advanced social workers who had all had a pretty definite curriculum, stress was laid upon sundry methods of analysis of social data after their collection. Among these methods of analysis was one which took up the question of the public, social, and personal aspects of whatever problem of maladjustment was in question. Another dealt with the analysis of the patient's subjective attitude to his environment and himself—a question of the passive voice. A third dealt with a method of analyzing data from the standpoint of the evils found in evidence, and for the purpose of orderly analysis, a tentative rough classification of the kingdom of evil was given.

In view of war contingencies, brief suggestions have been made as to the desirable content of courses for psychiatric social workers of value in war time and after.

References

1. Richmond, Mary E. Social Diagnosis. New York: Russell Sage Foundation, 1917.
2. Cannon, Ida M. Social Work in Hospitals. New York: Russell Sage Foundation, 1913.
3. Southard, E. E., M.D. Alienists and Psychiatrists; Notes on Divisions and Nomenclature of Mental Hygiene. Mental Hygiene, v. 1, p. 566–71, Oct. 1917.
4. Jarrett, Mary C. Psychiatric Social Work. Mental Hygiene, v. 2, p. 283–90, April 1918.
5. Flexner, Abraham. Is Social Work a Profession? National Conference of Charities and Correction, 1915. Proceedings, p. 576–90.
6. Gardner, Mary S. Public Health Nursing. New York: Macmillan, 1916.
7. Adler, Herman M., M.D. A Psychiatric Contribution to the Study of Delinquency. Journal of the American Institute of Criminal Law and Criminology, v. 8, p. 45–68, May 1917.
8. Adler, Herman M., M.D. Unemployment and Personality; a Study of Psychopathic Cases. Mental Hygiene, v. 1, p. 16–24, Jan. 1917.
9. Jarrett, Mary C. The Psychopathic Employee; a Problem of Industry. Medicine and Surgery, v. 1, p. 727–41, Sept. 1917.
10. Jarrett, Mary C. Shell Shock Analogues; Neuroses in Civil Life having a Sudden or Critical Origin. Medicine and Surgery, v. 2, p. 266–80, March 1918.
11. Myerson, Abraham, M.D. Neurosis of the Housewife. Medicine and Surgery, v. 2, p. 294–303, March 1918.

12. Solomon, Harry C., M.D., and Solomon, Maida H. The Family of the Neuro-syphilitic. Mental Hygiene, v. 2, p. 71–80, Jan. 1918.
13. Southard, E. E., M.D. Remarks on Industrial Accident Board Cases Examined at the Psychopathic Hospital. Association of Industrial Accident Boards. Transactions (in press).
14. Southard, E.E., M.D. Remarks on Psychopathic Problems in Industry. American Society of Mechanical Engineers. Transactions, Feb. 20, 1918.
15. Southard, E.E., M.D. The Major Divisions of Mental Hygiene: Public, Social, Individual. Boston Medical and Surgical Journal, v. 175, p. 404–06, Sept. 21, 1916.
16. Southard, E.E., M.D. On the Application of Grammatical Categories to the Analysis of Delusions. Philosophical Review, v. 25, p. 424–55, May 1916.

MENTAL DISEASE IN THE FIELD

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DURING a year's service as Regimental Medical Officer with the British Expeditionary Force in France, I had an opportunity to see a fairly large number of mental and nervous cases; and although, unlike physicians serving in base hospitals, I had no opportunity to make a careful study of my cases, I found some compensation in the fact that, serving in the line, I had a better opportunity to observe the conditions under which they developed and the practical problems which they presented to the military organization. I should like to review the principal types of cases that came under my observation and the causes to which they appeared to be due.

The cases to be considered may be conveniently divided into three groups:

1. Mental and nervous ailments existing at the time when the men suffering from them were passed as fit for service.
2. Cases of maladjustment to routine army life.
3. Mental disorders brought on by the strain of actual warfare.

Amongst the cases of mental and nervous disease passed as fit for service, there are some that any physician should be able to detect. For example, I found in a battery in France a case of cerebral syphilis with hemiplegia, which hemiplegia the history showed to have existed at the time when the man was passed as fit for service. Again, there are cases that get into the army which could be eliminated if recruits were subjected to a mental examination by capable psychiatrists. In this class fall many cases of mental defect and early dementia praecox. It would probably not be worth while to make a routine mental examination of every recruit; but whenever, in the course of the ordinary medical examination, the examiner has occasion to suspect the existence of mental disease, it should be possible for him to refer the recruit to a psychiatrist in order that a thorough mental examination might be made. By this means, without necessitating any great amount of work, cases could be eliminated which otherwise impose a considerable burden upon the military organ-

ization. For example, one mental defective who in civil life was a fairly efficient farm laborer, and who was therefore in the present emergency to be rated as an asset to the nation, was drafted into the army, where he proved to be absolutely useless. A brief mental examination would have demonstrated this man's unfitness for military duty. As it was, by taking him from the farm, the country lost not merely the value of his services there, but also the not inconsiderable sum spent in equipping and maintaining him in the field. More than that, by reason of the dullness he displayed in learning the drill and in all his work, he delayed the training and lowered the efficiency of the entire unit to which he belonged.

But although some cases of mental and nervous disease can be eliminated in the course of a formal examination, there are many others which cannot. For example, there are those cases of epilepsy which present neither physical nor mental indications by which the condition can be detected. Speaking from my own experience, I should say that epilepsy is a very common form of nervous disorder in the British army; and its prevalence would seem to be due in part at least to this difficulty in detecting it. Unless the recruit should happen to have a seizure during the examination, one is obliged to depend solely upon the history given, and this is apt to be of very little value. If the recruit desires to be passed for service, he commonly conceals the fact that he has had seizures; while on the other hand, if he is a slacker desirous to avoid the performance of military duty, his statement that he is subject to fits may be quite false. Neither are the statements of his friends to be depended upon, for they may be conniving with him. Even physicians, in the present war, have been guilty of making it their business to assist recruits to obtain exemption on medical grounds. In view of these facts, unless there is good evidence to show that a man is a genuine case of epilepsy, the examiner very properly gives the army the benefit of the doubt, and, if the man is otherwise sound, passes him as fit for service. The result is that a good many epileptics are passed into the army and have to be weeded out later.

The second group of cases consists of men who do not necessarily become insane, men who, owing to constitutional or acquired defect, are unable to adapt themselves to routine army life, and therefore cannot be made into good soldiers. The following is an example of this kind of case.

The man was an eccentric individual, intensely religious, obstinate, and of poor judgment. As a stretcher bearer he had shown unusual courage. Supported by the firm belief that God was always with him, guiding and protecting him, he had carried in the wounded under very heavy shell fire, showing no concern whatever in regard to his own danger. The strong religious faith and fixity of purpose here displayed would have been very valuable fighting qualities if they had been made use of only when in conflict with the enemies of his country. But the trouble was that this man showed the same reaction in his conflicts with the non-commissioned officers over him, being led into these conflicts by his lack of judgment and very peculiar religious beliefs. The result was that, not being amenable to discipline, he was useless as a soldier.

Such a man as this could not be classified as insane; and yet he was quite as useless and quite as much a burden on the military organization as if his abnormal tendencies had resulted in the development of some recognized type of mental disease.

There are, however, cases of maladjustment that do become insane. In such cases, we may assume that the man's mind is in a state of more or less unstable equilibrium, and that, when he finds himself in an environment to which he cannot adjust himself, the resulting disharmony existing between him and his environment so acts upon his mind as to upset its balance and bring about a psychosis. Such a case was that of a young man, sensitive, seclusive, and accustomed to a sheltered environment in which he had been able to keep very much to himself. On joining the army, he found himself compelled to eat, sleep, and spend all of his time in intimate contact with a body of men who for the most part were uneducated, rough and boisterous. Often this intimate contact with one's fellows serves to break down seclusive tendencies. In the present case, it served only to intensify them. The young recruit could not bring himself to mingle with his uncongenial companions; and being obliged to live among them although not of them, his position was a very uncomfortable one. It is easy to see how, being so situated, he became very self-conscious. He felt whenever the men laughed that it must be at him. He grew to believe that he was disliked. In this uncongenial environment he sank into a depressed condition, grew dull and sluggish. Thus it came about that he did not display the necessary degree of smartness on the parade ground and in his

work. His sluggishness caused him to be singled out for repeated reprimands from the drill instructors, and as a result he came to feel that the officers also were against him. So he grew more depressed and his ideas of reference more pronounced, until he was finally evacuated from his battalion as insane.

In these two cases, we see two types of maladjustment to the demands of army life. In the first, it was a failure to adjust to the disciplinary demand, the demand for obedience. To this demand the man responded with insubordinate conduct that made him useless as a soldier. In the second case, it was a failure to adjust to the social demand, the demand for that spirit of comradeship which cements together a body of men into an efficient unit. The recruit responded to this demand by drawing more into himself. The disharmony between himself and his comrades resulting from this type of conduct reacted upon him to disturb his unstable mental balance and to precipitate a psychosis.

In the army at the present time one meets a good many unadaptable individuals. In time of peace these men tend to escape attention. They are taken care of by relatives; they find some kind of niche in which they are able to earn a livelihood and get along after a fashion; or, not fitting in anywhere, they drift about, here today, there tomorrow, without receiving much attention from anyone. When, however, as at present, the manhood of the nation is called to the colors, these men are drawn in with the others; they are given a place in the military organization; and then a realization of their unfitness is forced upon us. What are we going to do about them? We might make an attempt to prevent them from entering the army, but such individuals are not easy to detect by means of a formal examination. More than that, men of low grades of intelligence, ill-balanced, even criminal types, men who seem unadaptable in civil life, often make excellent soldiers. To attempt to weed out all such individuals, therefore, is to deprive the army of some excellent fighting material, as well as to keep at home a class of men that the nation can very well spare. It is on meeting cases of this type that one is impressed with the absurdity of war, to which the nation sacrifices its strongest and best, while keeping at home the weaklings and the unfit to perpetuate the race. The only course possible with these ill-balanced individuals is to allow them to enter the service, and then to weed out in the training camps those who subsequently prove useless. However, in order to prevent such

cases proving a needlessly heavy burden on the military organization, medical officers should be educated in regard to them, so that they may be recognized early and disposed of without unnecessary delay.

In the group of cases resulting from war strain, the important exciting cause is found in the action upon the fear mechanism of the horrors and dangers of the battle front, of these shell fire being the most important. When a man is first sent up to the front, he generally is very much alarmed by the roar of the shells passing overhead. In a little while, however, he becomes accustomed to this. He discovers that his life is not seriously threatened every time a shell is heard; and so, as time goes on, shell fire troubles him less and less. Sometimes, however, we find the reverse of this. We find sometimes that a man (he may be a raw recruit or a seasoned veteran) gradually "loses his nerve." Shell fire which previously troubled him but little, now begins to worry him; he grows more and more apprehensive, until he may become quite unfit for service in the line and have to be evacuated. The following is an example of this type of case.

The patient was an artillery officer who for several weeks had worked unusually hard, and had been repeatedly exposed to severe shell fire. Under this strain he gradually became more and more nervous; and when I examined him, he had become so exceedingly apprehensive of shell fire that he was no longer able to control his fear. The shelling kept him awake at night. He was tremulous, complained of headache, and was no longer able to "carry on." It was therefore necessary to evacuate him.

A condition similar to the one just described may, however, instead of coming on gradually, be produced quite suddenly as a result of some particularly trying experience. For example, a man who never has been regarded as at all nervous some day has a shell burst very close to him. He is half buried by it, and perhaps his comrades are killed before his eyes. After this he can no longer control his terror of shell fire. He cannot sleep at night, and comes up to sick parade shaking from head to foot, probably much ashamed of his nervousness, but quite unable to control it. The following will serve as an illustration of this type of case.

The patient was a cool and efficient young officer, but within a single week he was exposed to three severe nervous shocks, which proved too much even for his apparently good powers of resistance. On the first occasion a shell burst close beside him, knock-

ing him flat on the ground and covering him with mud, but not wounding him. A couple of days later a shell burst on the edge of a trench in which he was standing, almost completely burying him. As far as could be seen as the time, neither of these shocks had any serious effect upon him. But the third experience followed only a couple of nights after the second. As far as can be learned, he was alone in an advanced position when a shell burst near him, flinging him to the ground. He must have picked himself up after this and found his way back to his billet, although he had no recollection of doing so. When I saw him the next morning, he showed no physical injury beyond a slight bruise on the forehead, probably caused by a lump of earth striking him. He was still slightly confused and complained of headache. He trembled violently, and the sound of shelling drove him almost into a panic. He was evacuated as a case of shell shock, and according to information received later, was not likely to be again fit for active service for a long time at least.*

In the cases just described, the condition seems to be the direct outcome of a stimulation of the fear mechanism through exposing the individual to one or more emotional shocks of greater or less severity. But all men at the front are subjected in a greater or less degree to emotional shocks. All are exposed to danger. What are the factors, aside from the severity of the shock, that determine which individual shall react with a psychosis and which shall remain unaffected?

The personality, the constitutional make-up of the individual, is certainly the first factor, one man being much more easily and profoundly affected by the dangers and horrors of war than another. The importance of this factor is so obvious and so generally recognized that it is unnecessary to enlarge upon it.

A second factor is fatigue, exhaustion, a condition of ill health. The physical strain upon the men at the front may be very severe,

*In reports from the hospitals of cases of shell shock, aphonia, monoplegia, and various other hysterical manifestations figure prominently. In the cases which came under my observation at the front, these hysterical symptoms were not present. I have talked with other medical officers similarly situated to myself, and their experience has been the same as mine. Of course, a Regimental Medical Officer sees at best only a small number of cases, and it would be unsafe to draw inferences from the experience of only a few men. Nevertheless, it seems not improbable that these hysterical symptoms are of late development. The patient has a monoplegia or aphonia only because he thinks he has, and as a rule he is well back from the front and on his way to the hospital before he has an opportunity to think of such a possibility. Hence, these symptoms are as a rule seen only behind the lines.

even when there is no heavy fighting in progress. Take, for example, a man who in peace time has led a sedentary life, his days spent behind a desk, his evenings by a warm fireside. He is drafted into the army, and after a few months' training is sent to join a battery in France. Here he works all day in the mud and snow, digging gun positions, carrying heavy shells; and in the evening retires, not in dry clothes to a warm bed, but to a dilapidated barn, where he wraps his blankets about him over his wet uniform and lies down on the floor to get as much sleep as his state of physical discomfort will allow. During an offensive, when the men may be obliged to work all day firing their guns and work all night shifting them to new positions, the physical strain is even more severe. With the lowered vitality resulting from such conditions, there is more nervous trouble, as well as more illness of every other kind. This of course is only to be expected. It is generally recognized in civil life that a person in poor health is more profoundly affected by any emotional shock than one in a normal condition. When we are tired or ill, little things worry and upset us which when we are in robust health do not trouble us at all. It is therefore to be expected that men who are in a poor physical condition should react more strongly to the emotional shocks of war than men in robust health. Along with the purely physical fatigue we must also bear in mind the nervous fatigue that comes from worry and anxiety. This of course comes mainly to the officers, upon whose shoulders all the responsibility for the work rests. It is no doubt owing to this fact that during an offensive the officers complain more of "nervousness" than do the men.

A third factor is the depression resulting from the monotony and discomfort of life at the front. Imagine a winter in France, spent as many of the men spend it, living in a hole underground, dark, narrow, unventilated, and often dripping with moisture, an abode compared with which the average coal cellar is both luxurious and cheerful. When a man leaves this, his home, it is merely to go out and wade in an expanse of mud, trenches full of mud, fields of mud, roads of mud; to engage in the most dreary, uninteresting round of duties, digging trenches or carrying up shells, while his wet clothing sticks to his chilled body. Subjected to this dreariness and discomfort, is it any wonder that some of the men become depressed, "fed up," that they come to care nothing about the war except how they shall escape from it?

I have seen a depression of the manic-depressive type result apparently from this cause and this alone, although such reaction is probably rather rare. Nevertheless the depression which all feel to a greater or less degree, although it seldom attains the severity of a definite psychosis, constitutes a condition of mental ill-health which is important for two reasons. In the first place, it means a general loss of morale, a lowering of the efficiency of the troops; and in the second place, it causes the soldier to react more readily to the horrors and dangers to which he is exposed. If a man's martial ardor is high, if his heart is in the fight, then his danger is as nothing to him; his mind is not upon himself; he feels no fear, and the shells falling about him affect him not at all. Take, however, the same man. Let him become depressed in spirit. Let him lose heart in the struggle. His thoughts now turn to himself and his unfortunate position. His chief concern is for his own personal safety. The result is that the falling shells, formerly regarded with indifference, now give rise to intense fear, and become capable of producing that condition of mind underlying what we call shell shock.

But these factors in the production of the war psychoses are complicated by another factor, a factor which has its root in the patient's own mind. This is the wish to be ill. Living under conditions that are at once dangerous, uncomfortable and monotonous, the men, as already pointed out, are apt to lose all martial ardor, to become utterly sick of the war, their only wish being to find some way of escaping from it. The soldier, in this state of mind, begins to hope for some illness, some wound not too severe, that will take him out of the line back into a safe, comfortable hospital, or, better still, all the way back to "Blighty." The first question the British Tommy is likely to ask when brought in wounded is, "Is it a Blighty touch, Doctor?" For this reason threatening ailments are hopefully watched and cultivated. I have more than once known a man to hold back from attendance at sick parade, hoping that his ailment, if left untreated, might become so serious as to necessitate his being sent to hospital. As a result of this mental attitude one finds all grades of malingering, from the shameless liar who presents himself at sick parade with a list of purely fictitious symptoms, up through the individual who really suffers from some slight ailment and like a good lawyer makes the most of his case, to the man who has really succeeded in making himself believe in the seriousness of his condition, who

has succeeded in developing a malady which, in the language of the psycho-analyst, is a "wish fulfilment." This wish to be ill we naturally find operating in our shell-shock cases. They are men who have had a rough time in the line, and the dread of returning to it always hangs over them. If they get better they will be sent back to fight, so some take good care not to get better.

In conclusion, I might call attention to the fact that in the cases resulting from war strain there is little if anything that is really new. Emotional shock, fatigue, etc., the various etiological factors which give rise to war psychoses, are all found operating in civil life; and as for the psychoses themselves,there is probably nothing in their symptomatology that cannot be duplicated in the ordinary psychiatric clinic of any large city. The difference between peace conditions and war conditions and the mental disturbances resulting from each, is not a qualitative difference, but a quantitative one. Under peace conditions, for example, men are subjected to emotional shocks in no way essentially different from those produced by shell fire. But under peace conditions these shocks are of rather rare occurrence, and as a rule so mild as to affect only those who are mentally unstable. Under war conditions, however, they are of constant occurrence, and frequently so severe as to affect the strongest and best balanced of men. Thus etiological factors and types of mental disorder to which formerly we gave little attention have, with the altered conditions produced by the war, suddenly thrust themselves upon our attention; and as a result there has been a tendency to treat of them as if they were something altogether new.

COMMUNITY RESPONSIBILITIES IN THE TREATMENT OF MENTAL DISORDERS*

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IN the early period of community organization in this country mental disorders were nowhere so well understood or so intelligently treated as they are now. Two conditions, however, which are frequent consequences of mental disorder early compelled attention; namely, disorders of behavior and dependency. At first the only organized provision made for persons suffering from these disorders had reference to these two conditions. It was the duty of the constable and the poor-master to protect the community from the acts of disorderly persons, and to extend to the dependent the organized aid which the community felt it necessary to furnish. For the disorderly insane person the lock-up served the same purpose as it did for the disorderly sane person, and for the dependent insane or feebleminded who were not disorderly the almshouse furnished food, shelter, and attention as it did to all other dependents. Little attempt was made, in those days, to inquire into the causes and conditions which occasioned behavior disorders or dependency or to provide for the special needs of individual cases.

As the communities grew in population and advanced in knowledge, however, the problems which arose in connection with this simple method of disposing of persons who were mentally disordered grew more complex and difficult, and the number and gravity of the cases in which the inadequacy of the method was exposed excited more interest and comment. To meet this situation, it became necessary to make a distinction between the disorderly sane and the disorderly insane, and departments in which the latter could be given separate care were established at the almshouses. The narrow barred cells, the heavy doors with peep holes, and the restraint apparatus which marked this development are still to be seen at many almshouses from which the insane have been long since removed. The constable and the lock-up were still utilized, but an effort was made to restrict their

* Read before the Connecticut State Conference of Charities and Corrections, April, 1918.

services to temporary needs. We have not yet completely emerged from this period in the care of the insane. In many communities throughout the country, probably in most, the only organized agencies for dealing with mental disorders are those which have to do with disorderly behavior and dependency, regardless of the cause. In fact it has been truly said that in the organized methods by which insane persons are still dealt with in this country examples can be found of every form of neglect and abuse to which the insane have been subjected during the past two hundred years. The surveys made by the National Committee for Mental Hygiene have furnished considerable evidence of this. To anyone who may be sceptical I would suggest the reading of an article entitled "The Insane in a County Poor Farm" by Dr. Thomas W. Salmon, which appeared in MENTAL HYGIENE in January, 1917. This is a true account of the provision which is made now for the care of insane persons by a prosperous community in this country.

Notwithstanding these residuals of a former period, however, great advances have been made in the care of the insane. The medical needs of the cases have always been recognized by some, and physicians and philanthropists have from a very early period of the nation's development been engaged in efforts to provide for them. Many of the almshouse annexes were gradually developed into separate departments or separate institutions under medical management. Private funds were applied to the establishment of high-grade institutions where the best standards could prevail, and some of the earliest institutions for the treatment of mental disorders in this country were of this type. Eventually the legislatures in one state after another took up the question of the needs of the insane, and now in every state may be found state hospitals, medical institutions in which provision is made for treatment and attention which will promote cure. At first these institutions were looked upon merely as asylums where the insane could find refuge from the ignorance and indifference which had previously characterized their treatment. With the general advance of medical and nursing knowledge and standards, and the further enlightenment of the public, it has become possible to elaborate them into truly curative agencies. Unfortunately, there are still many states in which the provision made by the State is inadequate for the total number which require it, and many are still cared for in the almshouses.

In several of the states, the number of which is steadily increasing, the whole burden of providing institutional care and treatment for the insane has been assumed by the state government. Wherever this has occurred, the result has been a better level of intelligence and humanity in dealing with the cases under institutional care. State care is properly regarded, therefore, as a goal to be reached in the progress towards an efficient public system for dealing with mental disorders. It accomplishes much more than the mere transfer to the state of the responsibility of providing institutional care. It raises the prevalence of mental disorders with their causes, prevention, and management into the dimensions of a state problem of the first class. And, while, after state care has been adopted, the first task to be accomplished is to bring all cases which require institutional treatment into state hospitals, it is soon found that this by no means accomplishes all that is required for dealing adequately with the needs. Unless the vital issues occasioned by mental disorders in the homes, the schools, the industries, and in social relations are intelligently grasped and dealt with by means of the state system, state institutions are liable to be looked upon as a resource which is only to be appealed to when complete separation of the patient from his usual environment has become imperative. They will still be regarded as asylums. In such case, their development is likely to be in the direction of great custodial centres, and economic and so-called business considerations in their management are likely to prevail over those dictated by science and humanity. This has happened in more than one state in which state care has been adopted under conditions of great promise. A system of state care must, to be effective, not only be adopted, but it must be planned and developed with reference to the known needs of the sufferers from mental disorder. A well-defined policy is essential and carefully prepared plans. The best plan is probably to divide the state into districts containing not more than 500,000 inhabitants each, and to provide a state hospital for each district. This hospital should be so conducted as to serve to the fullest extent possible the needs of the district in dealing with mental disorders. With this in view, the necessity of educating the public to a proper understanding of the purpose and advantage of the institution should be considered. Unless steps are taken to this end, the process of substituting for the prevailing views and methods the newer conceptions and resources will require a generation.

This necessity is all too frequently lost sight of and progress is thereby greatly retarded. The state hospital is to be regarded as a social welfare agency and a centre of information and useful service which can be confidently appealed to in dealing with the problem of mental disorders in the district which it serves. In states in which a state system of care of the insane has been most fully developed the lines of progress have been towards the application of this view. Developments have been made for the purpose of bringing the district hospital into more intimate relation with the needs of the various communities in the district. In some states nurses from the state hospital, and sometimes a physician, are sent to the communities to bring the patients to the hospitals. Out-patient departments are conducted in various parts of the district where persons who wish advice concerning mental disorders may apply. Social workers are employed to visit, at their homes, patients who have been discharged from the hospital or who may have applied at an out-patient department. These contacts with the communities have an educational value and furnish means by which the hospital may contribute to the management of the problem of mental disorders as they occur in the home, in the school and in the commercial, industrial and social life of the people. Instructive literature relating to the nature, causes, and treatment of mental disorders, and to the utilization of the resources of the hospital is widely distributed. The physicians of the hospital aim to inform the medical practitioners of the district and the public, by means of scientific papers and addresses, concerning the conditions met with in patients and the purposes and plans of the hospital. By these methods, a state hospital becomes an aggressive agency for dealing with mental disorders throughout its district.

The usefulness of a state hospital to the various communities of the district which it serves is, to a considerable extent, dependent upon its proximity and accessibility. When a district contains several counties, as is usually the case, the largest number of admissions in proportion to population is usually from the county in which the hospital is located, and the proportion diminishes with distance and inaccessibility. It is thus possible to obtain statistics that seem to show that proximity to a hospital for mental disorders increases the prevalence of insanity. What is really shown is that ease of access, and possibly correct information concerning a state hospital, are conditions which are

necessary to its highest usefulness. The proportion of cases in the more distant or less accessible counties of a district is not likely to differ to any great extent from that in the counties nearest the hospital. Unless, therefore, some other means for obtaining hospital treatment are available for the latter, many cases for whom such treatment is indicated must fail to receive it.

The extent to which a state hospital can be utilized, even by the community in which it is located, is also limited by the conditions under which patients may be admitted. Certain legal definitions and formalities prevail in determining the cases to be admitted to a state hospital. The patients must be insane within the meaning of the law. This indicates that cases for admission must be differentiated and selected from a larger group of cases of mental disorder existing in the community. The best system of state care which has yet been established does not undertake to provide hospital treatment for all types and grades of mental disease. The acute deliriums of fevers and intoxications, and the large groups of cases which are designated by the terms neurasthenia, hysteria, and psychasthenia, and several other forms of mental disorder, are, with the exception of a few of the cases in which the symptoms are unusually severe, not ordinarily included in the types for which hospital treatment is provided by the state. There must necessarily also, in all cases of mental disorder, be a period in which observations must be made, diagnoses determined, and arrangements made for admission to a state hospital when this is found to be necessary. This may be a very critical period in the course of the illness, and as first aid applied to an injury may determine the final outcome, so the early treatment furnished a case of mental disorder may be of the greatest importance in determining the further course and outcome. The first treatment of a case of mental disorder, as of any other form of disease, must ordinarily be given wherever the patient may happen to be when the need becomes manifest. In many instances the condition is only recognized when immediate treatment has become imperative. It seems quite unlikely that any state system will be inclusive or elaborate enough to provide for all grades and forms of mental disease which require hospital treatment. Needs will still remain which will require that some organized provision be made by each division of the state and each community.

The best test of any system of providing for the treatment of persons suffering from disease is to examine its operation in a

number of cases. A few years ago a study of this kind was made in one of the states for the purpose of ascertaining the methods and provision employed in the treatment of persons suffering from mental disorder previous to their admission to the state hospitals. This study covered the admissions during a period of two years. It was made easily possible because of the practice of sending nurses to bring the patients from the communities to the state hospitals, which has been in operation in the state referred to since the state-care act was adopted many years ago. These nurses were asked to make reports concerning the condition and environment in which they found each patient. The system of care in this state is considered to be as good as any in the country if not the best. The law under which it was established defined the types of cases which could be admitted to the state hospitals and the conditions of their admission. It was left to the local authorities, however, and to relatives and private physicians to provide the means for observation, first diagnosis and determination of the need of hospital care, and for temporary treatment. The study which was made revealed that, throughout the state, little advance had been made in the local provision and methods since the period when the behavior disorder and dependency of an insane person were the only issues that received organized attention. The poor-law authorities and the police were still the only officials who were required by law to see that an insane person received attention. It was found that in only one county in the state outside of that in which the largest city is located was there any organized provision made for temporary hospital-care and skilled observation or nursing. In the largest city provision for the termporary hospital treatment of mental cases was furnished at two general hospitals. More than half of the patients received at these hospitals were, however, brought in by the police. In the portion of the state outside this county, seventy-five per cent of the patients admitted to the state hospitals in the first year covered by the study were brought directly from their homes, and it was found that, of these, fifteen per cent or 410 persons during the first year covered by the study, had suffered from gross neglect or unintelligent harsh treatment. Some of these instances are as follows: (1) A woman was brought from her home where she had been in a disturbed state. She had been held in bed by a network of ropes, her ankles bound together, her knee strapped and mittens on her hands. The patient died a

few hours after admission and an autopsy disclosed a rupture of the stomach. (2) A woman was found at home where she was fastened to a chair by a sheet tied about her and nailed to the wall. She was confined in the room with her husband who was dying of pneumonia. The chair in which she sat was nailed to the floor. The doors of the room were nailed up at night. She was dressed in an undervest and men's trousers, and had been bound hand and foot in bed for a few days before she was transferred to the hospital. Many other instances could be cited. More than seventeen per cent of the patients, or 466 persons, received during the same period at the state hospitals from this portion of the state were found in jails, lockups and police stations. Eighty-seven of these patients were women. The reasons for confining the patients in these places were not always apparent from the reports. In some instances they were said to have been violent or otherwise dangerous, but others appeared to have merely been wanderers, or to have shown eccentric behavior or expressed delusions in public. Many of these patients were found in unsanitary, uncomfortable, sometimes filthy and vermin-infested cells, not infrequently in company with persons accused of crime. In one instance the patient was found in the same room with a person accused of murder and developed a delusion that she herself was accused of the crime. In another, a woman was found in a basement cell, without windows, with no toilet facilities, and separated only by a slat door from the quarters of a drunken man. The patients sometimes received what care was given from prisoners, or they were found in a common room with drunkards and tramps. In a jail in one of the larger cities of the state, a woman was found by the nurse in a cell which was so small that she could scarcely sit up in it. There were no toilet facilities accessible to her and she was entirely naked and extremely filthy and dirty. In a police station two male patients were found confined in a box-like structure with board sides and an iron grated top, hinged and fastened with two locks. When the top was closed, the patient could not rise from the recumbent position, and, as he lay there, the distance between his chest and the bars of the top was only six inches. Another patient was found in a cell which was not heated though the weather was cold. He was insufficiently clad and was so ill that he died two days after admission to the hospital. In a large number of instances, the report states, women were confined in station houses and lockups

without attendance by persons of their own sex. One insane woman was entirely nude in a cell and there was no one to wait on her except a man who brought her food to her.

To appreciate the significance of these methods of dealing with persons suffering from mental disorders, it is necessary to keep clearly in mind that they were found to prevail throughout one of the most progressive of the states in the care of the insane, in which an excellent system of state care had been in operation for nearly twenty years. This system was, however, devoted practically altogether to furnishing institutional care to persons who were delivered over to it by the communities. Nurses from the state hospitals were sent to bring the patients in, but there the active concern of the state system ended, and those who were interested in its development paid little or no attention to what was happening to the cases outside the hospitals. The inferior methods still employed by the communities were the outcome of the persistence of views and methods which regarded the dependency and behavior disorder of an insane person as the main issues. It was seen, therefore, that the first step towards improving the methods should be to place the responsibility for the care of the cases in the hands of some official who would be more likely to consider the medical needs of the cases the main issue. To this end, the duties of providing for insane persons were transferred by statute from the poor-law authorities to the medical health officers and the confinement of the cases in jails and lockups was forbidden. Since this change was made, the methods have been greatly improved, though the prevailing ignorance and low standards concerning mental disorders, even in the medical profession, hinder the development of the organization and facilities which are needed. Special knowledge, special skill, and in many instances special facilities must be available for the proper understanding and treatment of mental disorders. These are not yet demanded by the intelligence and interest in the subject that prevail in any community. They can be secured only through the efforts of a few specially informed and interested individuals. They would, however, I am sure be acceptable to the community, and willingly paid for as soon as their purpose and value were understood.

In every large centre of population a department for nervous and mental cases should be provided in connection with the best general hospital. This department should be so organized and

equipped that the patients would be treated by the most approved methods at the hands of specially trained and experienced nurses and physicians. In no class of case is the necessity for specialists more pressing. In fact special knowledge and skill are the only sure safeguards against gross neglect and mismanagement in the treatment of mental cases. The department should be open not only to the patients of the city in which it is located, but to those of the more easily accessible smaller communities where there are no hospitals. These communities would, through their health officers and the more enlightened citizens, probably have to be educated to bear the expense of the transfer and treatment of the patients. A comparatively few of the cases would, however, require hospital treatment until they could be sent to the state hospitals. Most of them could be cared for at home, with attention, in some instances, from a specially qualified nurse who ought to be obtainable from the hospital. It is discreditable to the intelligence and humanity of any community when no better provision for a delirious or frenzied sick person is made than the police station or lockup, and when no more skilled nor tender attention can be supplied than those of the constable and the poor-master.

The communities might also use to greater advantage the resources of the state hospitals. This is especially the case in those places nearest to the hospitals. Access to these resources should be as easy as possible, and means should be taken to inform the public concerning the methods and advantages. The hospital of a district is a centre of information and assistance in all matters relating to mental disorders. The communities should learn to utilize them fully, and the state system should provide for state supervision and standardization of local provision and methods. A system of co-operation may thus be established which will make it possible to secure good treatment for a patient during the whole period of illness.

The problem of mental disorders as now understood is no longer properly formulated by the phrase "the care of the insane." Mental disorders of many forms and in many stages are extremely prevalent. Those regarded as insane are simply the cases whose capacity for adjustment to the requirements of organized society has failed to such degree that they have become a burden or a menace. The problem of early treatment and of prevention can never be solved merely by the care of the insane.

Each community must take it up for itself and provide such organized attention as is given to any other social problem, for example, education, sanitation, transportation, etc. This view is already beginning to find practical application in the schools, in the courts, in the prisons, in the army and navy, and wherever departures from normal behavior require attention. It is of vital interest to all of us that the means provided for dealing with mental disorders in the community should be adequate. No one is immune from these disorders, and when a case occurs in a household in a community the situation is one which demands very special knowledge, skill, and facilities.

Permit me, then, in closing to suggest for your careful thought and investigation as you take up again your contacts and interests in your own communities the following questions:

1. If a case of mental disorder should occur in your household what would you do?

2. How and where would you obtain skillful medical and nursing attention?

3. If the patient were delirious, frenzied, or uncontrollable as is sometimes the case, how and where would you find near at hand a suitable place where he could be safely and properly treated?

4. To what extent is the state hospital of your district used by your community? Could its usefulness be increased?

5. If you find that the means provided for dealing with mental disorders in your community are inadequate can you not do something to improve them?

THE ORGANIZATION OF A STATE HOSPITAL FOR MENTAL DISEASE*

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THE demands of the army for physicians, nurses and attendants trained in psychiatric work have resulted in a serious condition of shortage in the supply of such persons for civil service. Under these circumstances it becomes more than ever necessary to organize the state hospital for operation at the highest efficiency in order, as far as possible, to offset the deficiency in trained help.

Fortunately, the increase in the number of committable cases of insanity resulting from war conditions has so far proved to be very small, and experience abroad does not justify any expectation of large numbers of cases of this kind. The main increase in mental disturbances concerns psychoneurotic and borderline conditions the care of which will take place largely outside the state hospitals which must, however, be prepared to assist largely in this work. I have been asked to confine my remarks to conditions within the hospital and therefore shall touch only incidentally upon this feature, although I am fully cognizant of its great importance.

In discussing the question of organization it is necessary first to consider the functions which the state hospital is called upon to perform and the results desired. For a long time such institutions were regarded as purely lodging houses for the segregation of those who, by reason of mental disorder, were unfit for ordinary social life. Gradually this gave way to the so-called "hospital idea," by which was meant an approximation of methods and equipment to those of a hospital for physical disease. While this represented a decided step forward it has nevertheless, in my opinion, been to some extent a failure for the reason that it has not taken sufficiently into consideration the very special character of the work to be done and the fact that many of the inmates will inevitably remain permanently within the institution although not "sick" in the ordinary sense of the word at all.

The recognition of the existence of mental disorder necessitating care in a state hospital does not have the same significance as the diagnosis of bodily disease requiring treatment in an ordinary

*Read before the mental hygiene section of the National Conference of Social Work, Kansas City, May 15–22, 1918.

hospital. Disease may, it is true, be present, but the principle fact is disorder of behavior and in the majority of cases no evidence of disease in the ordinary sense is to be detected. The hospital for the insane must, therefore, be organized primarily with the object of treating behavior, the ordinary practice of medicine being, though essential, a less important branch of its activities. Only when this is fully grasped and adequately provided for shall we be able to achieve even an approximation to the ideal hospital for mental disorders.

Behavior is in part the result of inherited nerve connections, but to a much greater degree it is the outcome of education and training. A state hospital must, therefore, be planned primarily as an educational institution. Its efforts must be directed toward the correction of faulty habits and the establishment of new ones designed to enable the individual to behave in a manner compatible with social life. Even when full correction is not secured, as unfortunately must frequently be the case either because the faulty habits have become too deeply ingrained before the individual comes under treatment or for some other reason, partial success may be accomplished and the patient become capable of living more or less satisfactorily in a modified or simplified environment such as in that of the custodial division of an institution or under supervision outside.

The education required does not differ in principle from that which is given to the child. We cannot hope, even if it were desirable, to remove feelings, desires and passions which are inherent in life itself. Our efforts, therefore, must be directed towards providing means compatible with social existence for the outlet of the energy which these emotions represent. This implies occupation endowed with interest, exactly that which we try to develop in children even though we perhaps do not plan our educational system with this consciously in mind. It must also be the corner stone of state hospital organization.

In planning the organization this central feature must be kept continuously in mind if we are to develop any purposeful and orderly system. In the past many of the arrangements have developed more or less in a haphazard way, alterations being adopted to meet emergencies without any organized efforts towards revision of the system as a whole.

Probably the simplest plan to follow in this article will be to trace the path of a patient through the hospital and to indicate

the various possibilities to be considered. This will afford a ready means for indicating the various subdivisions of the institution and defining their functions. Following this a few remarks on professional personnel and their economic employment will not be out of place.

The patient when first admitted will go into a reception division in which he is examined and studied with the object of determining the particular problems to be met and deciding the course of procedure to be adopted. As soon as this has been accomplished, a process which may take from a few minutes to several weeks, he will be transferred to the division in which it has been concluded he will receive the necessary treatment and care. This decision must be based upon the actual needs of the patient and not upon convenience in administration. This means that the various divisions must be organized upon a basis of therapeutic equipment.

At the time of admission the patient frequently shows more or less severe disturbances of conduct (often called the symptoms of acute insanity) which are reactions to the difficulties, of whatever nature, which have brought about the demonstration of faulty habits or behavior or, in other words, have precipitated the insanity. During this stage of acute mental disorder it may be necessary to await the arrival of a calmer period before attempting more active education and to confine our activities to meeting exigencies and dangers as they arise. This calls for expert skill and special equipment particularly in the nursing force. It, therefore, will constitute a separate division which may be called the division for acute mental cases. It should be constructed in small units to permit separation of patients and be planned especially to promote rest. Prolonged baths and conveniences for packs are essential. Facilities for simple employment, not as training but as an outlet for energy, must also be provided.

After the subsidence of this acute period, or immediately if such a stage does not exist, the patient should pass into a special division devoted to education. Such a division must provide for various kinds and grades of instruction and must be regarded as the most important branch of the institution. Upon the success accomplished here the whole future of the individual depends. Its functions correspond exactly with the reconstruction work which is being planned for disabled soldiers after the wounds causing the disability have sufficiently recovered. This division

should be able to provide material assistance to the Government in planning and carrying out such work.

It will be realized that, following the abatement of the acute stage of mental disorder, the condition of the patient may vary enormously. Let us take two extreme illustrations. The first patient is stupid, careless and untidy, shows little or no evidence of interest in his surroundings and, as is often said, is in appearance more or less completely demented. In most hospitals such patient is promptly transferred to the "untidy" or "back" wards of the institution, there to receive a postgraduate course in idleness and degradation. The proper destination of such individual is an environment in which continuous efforts are made to arouse interest and to rehabilitate the former self-respect. The man may have to be trained like a baby even in the simpler habits of self-care but if nothing more than this is secured the problem of his maintenance in the institution becomes enormously simplified. In connection with the treatment of such cases various stimulating forms of treatment, hydrotherapeutic, diversional and otherwise, are important.

At the opposite extreme, the subsidence of the acute stage may be followed by an apparent return to the individual's previous norm. He is then said to be convalescent. He is, however, not necessarily ready for discharge. The problem to be faced concerns not only his immediate recovery but still more the question of the prevention of future breakdowns. This may require special and even prolonged training in suitable habits of reaction and industry with the object of equipping the man better to meet the conditions of life on the outside.

Between these two extremes lie every possible gradation and variety each with its special problems, the number being almost as great as the number of individual patients.

The functions of this educational division are those of habit training which is to be accomplished by graded occupational teaching and the provision of graded responsibilities. It should be the prime object of the hospital to see that every patient who leaves the institution is better equipped to meet the world than when he entered, and that those who remain shall be prepared to be made useful to the full limit of their capacity.

As a result of the information gained from a study of the patient under these conditions and the progress he makes as a consequence of the training, there will develop, in the course of a

variable time, definite grounds for the determination of the future mode of life which it is desirable for each to adopt. This may be life outside the institution (with or without certain restrictions) or, on the other hand, it may be more or less permanent segregation from the complicated conditions of life in the world.

Leaving for the moment those persons who are discharged from the institution we may consider the division of the institution devoted to the care of those who will remain permanently within its walls. This division, the largest in most state hospitals, must be designed with a view of providing varying degrees of complexity of environment (which is largely a question of individual responsibility) and also toward making the lives of the inmates as comfortable and as homelike as possible. This does not imply either a hospital life or a life of idleness. To be happy every individual must be occupied. The form of occupation should be selected by reason of its fitness and interest for the individual, but here due consideration for the needs of the institution itself is permissible. The custodial division is thus also the industrial division. Not only will economy in administration be promoted by this arrangement but the welfare and happiness of the inmates will be greatly enhanced. Systematic industrialization of the state hospitals is a most urgent need, for nothing is more detrimental to the patient or more heart-rending to the observer than the rows of idle, so-called dements who fill their "chronic" wards.

The training given in the educational division may well be planned to prepare such patients as are expected to stay within the institution for the performance of the various kinds of industrial work which are being undertaken by the institution.

It cannot be too strongly insisted upon, however, that occupational therapy, the name customarily given to the work of the educational department, is absolutely separate and distinct from industrial employment. The latter may, indeed, be regarded as graduate work, but in no case should the industrial needs of the institution be put ahead of the therapeutic requirements of the individual patient. The case of the institution, in this regard, does not differ from that of the world at large. A child is educated first and only later is permitted to enter industry. To attempt to interfere with this provision in ordinary life has always led to disaster. This is evidenced by the enactment of laws prohibiting child labor and even more emphatically during the war, both in this country and in Europe, when efforts were made to

relax the school and training conditions in order to allow early participation in work essential for the conduct of the war. Universally it has been found that there followed an enormous increase in juvenile delinquency. We may well apply this experience to the state hospitals and realize that an effort to cut down or eliminate the training period is bound to lead to failure.

The organization outlined thus far then provides for the following divisions:

1. A reception division,
2. A division for the care of acute mental cases,
3. An educational or reconstruction division,
4. A custodial or industrial division.

To these must be added

5. A hospital division,
6. An infirmary division,
7. A laboratory division.

The hospital division has as its function the treatment of the physically sick and will require medical and surgical equipment similar to those of a general hospital. It must also provide for the care and segregation of various infections such as tuberculosis and the contagious diseases.

The infirmary division is a department in which the more or less helpless results of organic disease are cared for, the terminal stages of general paralysis of the insane, senile dementia, etc. This should contain the only untidy cases permissible in the institution, cases in which the lack of self-care is due to structural defect and not merely to bad habits. These latter make up by far the larger proportion of the inmates of the "untidy wards" of most institutions.

The laboratory division needs but little description. Its functions correspond with those of any well-equipped general hospital.

The organization into divisions here outlined does not differ greatly perhaps in its general arrangement from that which obtains in many hospitals. I would insist, however, that it does differ in that it presents a clear definition of the functions to be performed and is built up around an eminently practical plan of therapeutics.

The personnel of a hospital can profitably be divided into professional and administrative branches. This subdivision means something more than mere words. I am convinced that if its true significance is realized and acted upon that very considerable economy in material may be accomplished.

The professional branch, with which alone I propose to deal, includes the medical, nursing, attendant and special therapeutic services. For all such work special, and often prolonged, training is necessary and it is in these fields particularly that the greatest demands are being made by the army. It is obviously wasteful to employ a highly trained individual to perform work which could well be done by unskilled persons. In the hospital, organized as planned above, the great need for physicians trained in psychiatry obviously lies in the receiving, acute mental and educational divisions and it is here that they should be especially concentrated. The work in the hospital, infirmary and custodial divisions can be carried out by physicians of less psychiatric experience, but there should be some arrangement whereby cases requiring special study could receive the benefit of such experienced physicians as are available. For this purpose it would be well to provide certain wards for special observation which could be under the same direction as the more acute services. Under present conditions laboratory work, which will of necessity be largely routine, can be placed in the hands of trained women technicians.

A great deal of a physician's time in state hospital work is often wasted in performing simple routine duties which could well be delegated to a clerk or some similar person. We have recently instituted in the Illinois hospitals a system whereby a clerk is employed to act much as a secretary to the medical staff. By observing certain rules for minimum requirements she is able to keep track of the duties which should be carried out each day, to see that patients and records are in readiness for the physician, that the purely formal data in various reports are filled in and, by making appointments with visitors, to see that unnecessary interruptions of the physicians' time are avoided. The system also enables one experienced physician to arrange his service so that much of the necessary routine medical work can be allotted by him to assistants (women or men unfit for military duty) who perhaps are not trained in psychiatry. This has resulted in a very marked saving of time and greater efficiency in spite of the reduction in the numbers of trained physicians available which we, in common with other states, have suffered.

The nursing service can be improved in like manner by cutting out unessentials from the duties of those who are trained. The training of nurses for psychiatric work is another field, the im-

portance of which has been brought home to us by the war. Most hospitals today maintain training schools for nurses, but unfortunately the training given takes but little account of the special work that these nurses are to be required to do. It aims rather at producing a nurse cast in the same mold as the nurse in a general hospital. In my opinion our training schools should be planned to develop nurses fitted to care for mental and nervous cases and we should hire, already trained, such nurses as we need for the care of bodily sickness. We have been working on such a scheme in Illinois for the last few months and hope to have the new training school at work this coming fall. The backbone of this course must be habit training and occupational therapy which we have adopted as the corner stones of our divisional organization. Such nurses will be required only in the earlier divisions considered. Attendants, adequately trained, will be employed for the care of custodial cases.

In the educational division there are needed workers especially trained in occupational teaching. Much of this work will be done by nurses of the special training school alluded to but, for the present at any rate, it seems necessary to secure some one who can devote the whole time to the supervision and direction of the activities in this division. This, of course, does not relieve the psychiatrist from the duty of deciding and prescribing the proper treatment for each individual.

Lastly, reference must be made to a division the work of which lies in part outside the walls of the hospital, the social service department. The state hospital, from the nature of conditions, possesses almost a monopoly upon psychiatrists and is unquestionably the center from which must radiate all efforts toward prevention and after-care. The staff must be so organized that the physicians can take part in the mental hygiene work of the community and there should be some provision made for the reception of patients for temporary study and observation with the object of determining the proper treatment necessary.

Reference was made above to the maintenance of special observation wards in connection with the acute (as opposed to custodial) service for the special study of difficult cases. These same wards should also be open for the reception of "temporary care" or voluntary cases brought in from the outside for diagnosis and not necessarily subjects for commitment. It is this class of case which is being brought more prominently forward by war conditions and which the state hospital must be prepared to assist.

SUPERVISION OF THE FEEBLEMINDED IN THE COMMUNITY*

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THE social significance of feeblemindedness is becoming increasingly apparent each year. In the impression which it has made on the popular mind as a practical problem demanding a practical solution it has far outstripped the more interesting and difficult question of mental disease with which it is so closely allied but which is still a comparatively unknown quantity even to the more enlightened. To one who works in the field of mental disease, there is something very heartening in the familiarity which the ordinary teacher or social worker now shows toward feeblemindedness as a possible factor in her work. This quite general recognition of the importance of mental defect for the community in marked contrast to the prevailing ignorance of the social importance of mental disease is not difficult to explain.

Of all the problems presented by mental hygiene, feeblemindedness is the simplest, most accessible and most easily comprehended by the common man. Anything that can be stated in terms of intellect is simple compared with that which goes over into the fields of emotion, feeling, impulse and instinct. It may be that such a confining of feeblemindedness to the intellectual sphere will prove to be an over-simplification of the problem, but the fact remains that this way of looking at it has made it easy to explain and easy to understand.

This accessibility of the intellectual factor in feeblemindedness has also made it one of the first problems to lure academic psychology into the practical field, for the intellect is much more readily open to experimental laboratory methods than the will or the emotions. There is no question but that the swift rise of the mental test as a center of interest and experiment in applied psychology has had much to do with the growth of popular recognition of feeblemindedness as a social problem. Parallel to this

*Read before the Mental Hygiene Section of the National Conference of Social Work, Kansas City, May 15–22, 1918. General topic of the symposium of which this was a part, "Steps Necessary in Community Control of the Feebleminded."

development of psychology and aided by it has been the advance of criminology which by its disclosure of the intimate relationship between mental disability and antisocial conduct has perhaps done more than any other one thing to force the problem of feeblemindedness upon the public.

Organized charity with its unimprovable cases, agencies dealing with illegitimacy and sexual immorality of all kinds—all these have added their weight to the movement. Then still closer to the mass of the people comes the public school, so long trammeled by the presence of the feebleminded child who by definition is the stumbling block *par excellence* in the way of all orthodox teaching. In the recognition of the feebleminded child the school is on the way to a solution of one of its most serious problems, and the altering of an entire school system to make special provision for such children has done much to enlighten the common people.

It only remains for the final impetus to come from industry now strained to the last notch by the demands of the war. The recognition of the part played by the feebleminded workers, combined with the problem which mental deficiency is making for the new National Army as shown by the discharge of more than 4,000 feebleminded soldiers ought to give all the additional push needed to bring the country to a complete realization of the necessity of working out a plan for state control.

While feeblemindedness as a problem in mental hygiene may be comparatively simple, as a problem requiring definite social action it could hardly be more complex. It is the old question of reconciling the welfare of the individual to the good of the community which is particularly trying when the individual in question is not capable of taking his own part. How can modern society prevent the feebleminded population from becoming a dead loss economically? How can it guard itself from the injury which the feebleminded have the power to inflict upon the present and upon future generations and still be fair to individuals, the majority of whom have a certain right to life, liberty and the pursuit of happiness comparable in a degree at least to that of children whose interests we guard so carefully. Moreover we have to remember that the feebleminded person especially of the moron group is not an isolated individual without family ties. He belongs to a home whose love for him and belief in his possibilities will have to be taken into account in any plan we may formulate. No plan which ignores

human relationships and public sentiment will be successful, although innumerable laws confirm it.

If we approach the problem in cold blood, we may say that the only questions to be considered are the prevention of propagation on the part of feebleminded persons, the prevention of delinquency, and the most effective utilization of the labor represented by the feebleminded population. Nothing is simpler than to give the logical solution to these problems. The reason such solution is not simple in practice is that human life is not primarily logical. We are still a long distance from conscious intellectual control of social life, and even so the most rigorous intellectual control would obtain its results only through taking into account the working of human impulse and emotion.

Sterilization of the feebleminded is logically the solution for the problem of prevention of propagation of the mentally unfit where feeblemindedness is due to heredity. Practically, despite legislation, it has never worked because it is a purely intellectual remedy. It has never considered the prolonged period of preparation and education necessary to change deep-seated primitive attitudes. There may come a time when sterilization of the unfit will be incorporated in our program but it will be only when the general level of enlightenment on social problems is materially raised by slow growth.

Segregation much more than sterilization offers a practical solution to part of our problem at least and may eventually be the final, most practical solution. At present it fails in two, possibly three, respects. First, on the human side, when by segregation we mean a fairly complete shutting off from society of all the feebleminded including types of the higher grade, we ignore a profound aversion on the part of people in general to confinement for life for any human being, particularly when no offense has been committed commensurate with such punishment and when the individual to be segregated seems to the ordinary observer not to be very different from himself. This combined with the feeling which relatives, particularly of the high-grade feebleminded, have against segregation, makes any very complete program of this kind quite impossible for some time to come.

Quite aside from the obstacles presented by popular sentiment, there is one fundamental difficulty in the way of segregation as a complete program, on the purely economic side, and another

which may or may not be fundamental. If the most conservative estimates regarding the percentage of feebleminded in this country now under suitable institutional care are correct, it still remains to provide institutions for at least fifty per cent of the total feebleminded population of the United States. According to Mr. Kuhlman in the Journal of Psycho-asthenics for September—December, 1916, estimating that five-tenths per cent of the entire population is feebleminded, not five per cent of the total feebleminded population is now segregated in institutions for the feebleminded. Even if one disagreed with this estimate, it could be made far more conservative and still leave us with the task of housing a tremendously larger number of feebleminded than any state has ever contemplated. Any approach toward complete segregation is bound to mean a construction of institutions on a scale which will postpone realization of the scheme to an indefinitely distant future. In the meantime the feebleminded are with us, at large in the community for good or ill, with no conscious control of the situation on our part.

The other point to be considered on the economic side is the utilization of the labor of the feebleminded. We have no conception at present of how much of the rough work of the world is being done by morons. We are just beginning to get some return from the labor of the feebleminded in institutions through the rise of the colony plan in a few states. But we have no basis for deciding at present whether segregation can ever be made to utilize the labor of the feebleminded to as great economic advantage as some other plan which would allow of the employment of feebleminded in the industry of the outside world. This is a question for consideration and for further investigation that we may gain facts upon which to make a judgment.

Practically, then, sterilization from the point of view of human prejudice and segregation from the standpoint of human rights and economic possibility do not constitute an adequate program for the care of the feebleminded population of the country at least for the next quarter century. Even though we press sterilization into service just as far as popular sentiment can be made to tolerate it and though, regardless of sentiment, we construct institutions to the limit of the common purse, making full use of the cheaper plants offered by the colony plan, we shall still have a large problem untouched in the feebleminded at large in the community. Shall we continue for the next twenty-five years to

depend entirely upon segregation and remain in ignorance of the facts regarding the lives of the feebleminded outside institutions?

How can we decide whether all the feebleminded need segregation, how can we be sure that every feebleminded person is a potential delinquent until we know how many of the steady though humble and unskilled workers of the world are intellectually superior to the feebleminded delinquent or segregated case in the institution for the feebleminded?

Our knowledge of the feebleminded is based almost entirely upon our knowledge of intellectually inferior individuals who make trouble for us in society. Is it impossible that there is a class of individuals who by any intelligence test will measure down to the level of the institutional cases whom we label feebleminded, but who are not social problems? The whole question of feeblemindedness seems to be complicated by the question of how much of the antisocial or inefficient conduct of the types of higher grade may be due to the intellectual defect and how much to the emotional make-up. That is, may there not be as much temperamental variation in the feebleminded as in the intellectually normal? And that being the case may not the standard of feeblemindedness indicating segregation be as much a matter of type of emotional and impulsive make-up as a matter of degree of intellectual defect?

In other words, we seem never to have made any real attempt to study the problem of the feebleminded in the community to determine (1) whether there is any class of people apparently feebleminded by our intelligence standards that actually does get along in the world (2) to determine what real supervision, intelligently conceived and applied, can do to make the existence of certain feebleminded individuals outside of institutions safe and economically advantageous to society when it would otherwise not be so (3) to find in how far the so-called feebleminded delinquent is innately vicious and how far he is the result of prolonged maladjustment due to defective intellect, emotional and impulsive make-up, complicated by bad environment and training; i. e., may it not be possible that even in the field of intellectual defect the insight of modern psychiatry as to the mental mechanisms which produce maladjustment in the intellectually normal may have a bearing?

The *best plan* for supplementing segregation and sterilization for the present, even though they should ultimately prove to be

the only solution to our problem, the *only way* to obtain the kind of information we need and must have about the feebleminded, the *best scheme* for educating the people to a comprehension of the problem and a willingness to accept segregation and sterilization when necessary, is, it seems to me, the plan for careful scientific supervision of the feebleminded in the community as part of a state or nation-wide program for control and prevention of feeblemindedness.

I have no theory that the majority of the feebleminded would become industrially efficient, sexually safe or economically self-supporting, if only they could be supervised. I have no illusions regarding the difficulty of providing anything approaching adequate supervision, but I am convinced that for the present there is no other way of getting at the problem and after all, it is not as if we had not already taken upon ourselves responsibility for trying out such plan when we began the movement for ungraded and special classes for feebleminded children. Is that work all to be wasted? Are we to look after these children until they are fourteen or sixteen and then suddenly throw off all responsibility even to the extent of making no attempt to provide institutional care when it is obviously needed?

The school and the ungraded class give us the nucleus for a system of supervision which could be worked in so simply that it would not only not meet with opposition but would be welcomed by the children and by the parents.

In order to make such system of after-care effective in a school system, three things are essential: (1) an adequate mental clinic under the direction of a psychiatrist with psychological training or of a psychologist with psychiatric viewpoint and experience. This clinic ought to provide a routine method of passing on the mentality of every child who enters school in order that the assignment of the child to a special class should not depend chiefly on chance, and should not be delayed for several years while the child is struggling vainly in the regular grade and getting the full effects of his maladjustment. This clinic should be the center for a system of registration for the direction of social service and after-care and for the vocational guidance of the feebleminded child both in his industrial training and in his placement after he leaves the school. (2) The second essential of supervision is social service from the time the feebleminded child enters the special class. If a trained social worker with psychological background

could act as visiting teacher for the special or ungraded classes, keeping in touch with both child and home, following the child's development, keeping track of his conduct out of school, educating his home to a right attitude toward him, helping him to use the best recreational conditions the neighborhood affords, when the time came for that child to leave school, the combined knowledge of the teacher, social worker and clinic director ought to give a reliable basis for deciding what should be done with him. They would know what his abilities were, what his chance of industrial success, what his tendencies to antisocial conduct and, if he seemed to demand institutional care, the friendly relationship with the parents built up by the social worker would offer the best possibility of inducing the parents to permit segregation.

(3) The third necessary factor in a system of supervision is a vocational and employment bureau which shall be merely another phase of the mental clinic and the social service. This bureau would not only attempt to place the feebleminded child in an occupation for which he was fitted, but it would continue to supervise him carefully through the social service worker. Such supervision would do much to keep the feebleminded child steadily at work, not only because the worker could come in at a crisis to help adjust his difficulties and tide him over a period of discouragement, but because the worker would explain the child to the employer and through her ability to adjust problems as they arose would make the employer willing and able to keep a class of workers who might under ordinary conditions be impossible. The bureau would have to work up the whole problem of employment of the feebleminded—finding where the feebleminded child can best be utilized, interesting employers in the possibility of making conscious use of feebleminded labor, inducing them to try various experiments with such labor under supervision.

It may be argued that this system to be at all adequate would be expensive out of all proportion to the results. In answer to that it may be said in the first place that we know nothing about the results, certainly not from any experience in this country. In England and Germany and one or two other countries, a certain amount of after-care has been tried with rather poor returns in the case of England and apparently good ones in the case of Germany. I very much doubt whether such after-care has been done with any but volunteer workers and under any but fairly haphazard and unscientific direction. It seems to me we shall

have no grounds for judging the effectiveness of a careful scientific system of community supervision, until we have given at least a five-year trial.

As a supplement to supervision through the school system, we have in the institutions for the feebleminded, especially those with the colony system and field agents, machinery all ready to our hand for the supervision of institution cases who have improved with training and proved themselves fit for a greater measure of freedom. The institution for the feebleminded is also the logical laboratory center for the schools in its district, and school and institution might well combine on a thoroughgoing plan of training and community supervision wherever possible.

That supervision will be expensive, there is no doubt; but there seems to be no way to avoid the expense entailed by the production of the unfit. Segregation is expensive, special classes are expensive,—although perhaps no more so than institutional care for children who are too young to make any return in productive labor,—the feebleminded at large in the community unsupervised are expensive. It is not a question of whether we shall or shall not pay for the care of the feebleminded. It is merely a question of whether we shall pay blindly or consciously, whether we shall pay in crime, in courts, in reformatories, in prisons, in almshouses, or whether we shall pay in directed care calculated to give us the facts which may in time make control and prevention of feeblemindedness possible.

It may be argued that such scheme is impractical because of the numbers to be supervised and the necessity for real supervision if the plan is to amount to anything.

From one point of view any complicated extensive task involving care of many human beings is impractical, it is never done simply or easily. The effective education of children in schools is a gigantic task, seemingly almost impossible of accomplishment. But we never consider abandoning it because results are not always ideal or economically profitable. Successful supervision in the community is coming to be the final aim and ultimate criterion of achievement, for the hospital, the prison, the court, the reformatory, and the hospital for the insane. We call these systems probation, parole and after-care, and no one questions their value or measures them by their economic advantage. It really is not a question of whether or not a system of community supervision of the feebleminded will be simple or cheap.

It is a question of when we are going to begin to do this thing which has to be done before we can get any farther with the problem of feeblemindedness, and how long we are going to flatter ourselves that the money for ungraded classes is well spent while supervision ceases when the greatest need for it begins. There is no use training children for the scrap heap. If supervision is too expensive, ungraded classes are rank extravagance.

Finally, to sum up, a system of community supervision of the feebleminded in connection with the school system is absolutely necessary for a term of years, (1) in order to deal with the problem of control and prevention of feeblemindedness while segregation and sterilization are as yet inadequate, (2) in order to get facts regarding the feebleminded who can and those who cannot be adapted to life outside an institution, (3) in order to determine whether there is anything better than the colony plan for utilizing the labor of the feebleminded, (4) in order to educate the community to an understanding of the problem, (5) in order to justify the existence of special or ungraded classes and render them really useful, (6) in order to provide an opportunity for the study of the individual cases not *a priori* delinquent or belonging to the group obviously requiring segregation.

Dr. L. Pierce Clark in a recent article* has put the matter in a nutshell when he says: "We shall never arrive at any proper understanding of the causes of prevention of feeblemindedness until we reconcentrate ourselves anew to the individual case studies and make them thorough and detailed and see where they lead us, instead of studying this class *en masse*, which has been the popular mode of late. . . . Psychopathic traits, or, better, conduct disorders in the mentally-retarded and arrested children, need to be considered and studied on the broad plane of our present-day knowledge of personality and psychiatry."

* MENTAL HYGIENE, v. 2, p. 23–33, January 1918.

THE NEXT STEP IN THE TREATMENT OF GIRL AND WOMEN OFFENDERS*

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Reformatories for women are not now meeting the needs of the women sentenced to them by the courts. We reach this conclusion from a conviction that with so poor a tool no worth-while result can be achieved.

A reformatory which receives women from all the courts of a given state has within its walls a group of people whose only common denominator is crime. How diversified such a group may be is shown in Chart 1, which is an analysis of the population of the Reformatory for Women of Massachusetts in 1915.

CHART 1

	No Nervous Defect	Neuro-paths	Psycho-paths	Epilep-tics	Hyster-ical	Total	Total Per cent
Imbecile	5	0	1	0	0	6	1.2
Moron	33	16	4	15	6	74	14.8
Subnormal	40	49	22	25	9	145	29.0
Dull	36	32	11	15	8	102	20.4
Fair	24	10	13	13	8	68	13.6
Good	44	24	11	13	13	105	21.0
Total number	182	131	62	81	44	500	
Total per cent	36.4%	26.2%	12.4%	16.2%	8.8%		100.%

To turn such a group as this into a family whose chief purpose is re-formation of moral standards is to attempt the impossible. They have no common sympathies, no mental loyalties, no common ideals.

Let us forget, for a moment, that we are talking about reformatories or prisoners. Just suppose, for the sake of argument, that we are discussing a new state project in which it is proposed to build an institution to house epileptic, feebleminded, psychopathic, hysterical, neurasthenic, and normal women, who range in mentality from imbecile to high-school grade, with twelve

* Read before the National Conference of Social Work, Kansas City, Mo., May 15–22, 1918.

per cent illiterates, foreign and native. One immediately sees how impracticable such a plan is. If such a group were to be brought together for any single reason, for appendicitis, for heart trouble even, one would pity the administration.

This is, however, the situation of our reformatories because this is the kind of population going through our courts, since no state has developed the policy of caring for its criminal women on the basis of an analysis of its criminal population. Reformatories, therefore, cannot meet the needs of the criminal women because they are not equipped to handle so complex a share of the state's burdens as falls to their lot.

A state reformatory or state training school should not transfer sane patients nor discharge them into the community as "unfit subjects," short of the maximum sentence, unless cured; it should make of itself the state laboratory on delinquency and by its studies should shape the state policy for the treatment of *all* of the state's delinquent women. There should be no tag ends to relieve administrative strain; the tool, by which I mean the reformatory, should be made strong and flexible enough to do the job so that no phase of the woman criminal problem should be left untouched. We ask, at last, to be conscious of it *all*. By conscious, we mean having a full realization of the needs of each prisoner and the possibility of fullfilling those needs, be they re-education with a view to reinstatement in the community, or hospital treatment to correct nervous defect, or permanent custodial care. The question may well be asked why mix hospital care with reformatory treatment; that is, hospital care of the kind required for the treatment of psychopathic and neurasthenic women, with reformatory treatment, which used to mean fitting people for community life. The answer is that the next step in the treatment of criminal women necessitates such action.

The states which build reformatories now are either going to begin shortly to transfer their unmanageable types to the state prison (that is, to the female annex of the men's prison), or what is just as bad, there will be agitation for the building of a women's prison to relieve the reformatories of their unruly inmates. An unmanageable woman prisoner is so because of nervous or mental defect, or both, and no prison discipline will overcome that defect. If the Women's Reformatory of Massachusetts, an institution with forty years' experience, has done nothing else for the cause of the criminal women, it has demonstrated that no women's

prison is necessary; that no men's prison should have a female annex; that women prisoners should not be classified according to age or crime. It was built to duplicate, as nearly as possible, the men's prison. Time and use have modified its work; it has 60.7 per cent misdemeanants, 37.6 per cent felons, and 1.5 per cent lifers. So far as these crime designations go, they have no influence on our work; it is the personality of the woman that counts; it is the type to which she belongs which affects her harmfulness or helpfulness in the institution group, and which determines the kind of treatment she must receive. This being true, what is our next step?

Women criminals divide themselves roughly into three groups:

1. Those who may safely be returned to the community after training.

2. Those who need permanent custodial care.

3. Those about whom prognosis is doubtful, because they have formed the disciplinary problem wherever they have been, and for whom no method of treatment has been worked out.

With the plan of Chart 1 as a basis, Chart 2 has been drawn up analyzing the 5,310 women criminals of Massachusetts who were on probation or sentenced to institutions in 1915, the year for which Chart 1 was made. I realize that such an analysis can only be tentative, but it is good material from which to argue.

CHART 2

	No Nervous Defect	Neuropaths	Psychopaths	Epileptics	Hysterical	Total	Total, Per cent
Imbecile	53 1.0%		11 0.2%			64	1.2
Moron	350 6.6%	170 3.2%	43 0.8%	159 3.0%	64 1.2%	786	14.8
Subnormal	425 8.0%	520 9.8%	234 4.4%	265 5.0%	96 1.8%	1540	29.0
Dull	382 7.2%	340 6.4%	117 2.2%	159 3.0%	85 1.6%	1083	20.4
Fair	256 4.8%	106 2.0%	138 2.6%	138 2.6%	85 1.6%	722	13.6
Good	467 8.8%	255 4.8%	117 2.2%	138 2.6%	133 2.6%	1115	21.0
Total	1932 36.4%	1391 26.2%	660 12.4%	859 16.2%	468 8.8%	5310	100.0

		Number	Per cent
Group 1	Normal	1,104	20.8
Group 2	Feebleminded	850	16.0
Group 3	Subnormal Neuro-psychiatric	3,356	63.2
		5,310	100.0

Given this as the woman criminal problem, it is surely obvious that a "reformatory" as we now think of that institution, cannot meet the needs of these women. Is it evident that a "reformatory" is not even necessary? Has the time come to give up "reformatories?" Are they going out?

In 1915, probation in Massachusetts carried 2,783 women. This chart says there were only 1,104 mentally and nervously normal women in all that year. Probation then was hampered with a large number of women who should never be dealt with on probation. Could probation handle all normal women who commit crimes? Numerically, yes. How about putting a murderess on probation? It has been done and done successfully. There should be no limit to the possibilities of probation of normal women, because probation has all of the community resources at its disposal. Because of its low per capita cost the state could well afford to keep the number of probationers to each probation officer low. Probation officers would know better than I whether their technique would meet the needs of a criminal population of normal women of this size. Theoretically it should be able to do so.

The second group are those who should have permanent custodial care. There are, in this analysis, 850 feebleminded women who would need such care. These women should form a farm colony group in buildings of the simplest construction. Perhaps when their restlessness for city life wore off, they might be given under good leadership the problem of reducing the state's importation of poultry and eggs. They might—we may be too optimistic—with a combined truck garden, poultry farm, and light state-use industries for instance, be made self-supporting. However that may be, with their defective minds they should never again be called criminals, and they are not reformable in the reformatory institution of today.

The third group are those about whom we know the least. They have formed the major disciplinary problem wherever they have been and were long supposed to be just bad. In some institutions they are chained to the floor, the administration being utterly at a loss how to manage them. At an earlier stage of our social history one can imagine them being burned as witches; they certainly act possessed. If they were to commit murder, a plea of insanity might be filed, but when they are torturing themselves or the administration or fellow prisoners, alienists will not

call them insane, and insane hospitals discharge them. Have they a socially available norm of conduct? This is the crux of the next step in the correctional treatment of criminal women. The question can never be solved by a reformatory as we know that institution.

The problem is not one of giving in to the whims of nervous women; it is not a question of conduct color-blindness on their part, but a question of basic nervous defect as real as the loss of an arm is real to the physical body or as insanity is real to one's mental self.

A psychopathic or epileptic woman is a nervous cripple; her struggles for social adjustment are those of a soul pent up in an uncongenial body; every struggle she makes plunges her deeper and deeper into behavior complexes until the last stage is worse than the first.

Do you ask the question, "Why is this a reformatory problem?" Because her conduct creates a public order, police, court problem; i. e., a crime problem; and, of course, the word re-form does not preclude medical care. It excludes nothing, no effort that will remake the individual. Those who are in this work have the right to unlimited materials to aid them. Reformation does not mean, *keep that prisoner safe from doing harm to me;* but rather, *make that prisoner over so that she may join me safely in the community.* No tool, no material, no science, no skill should be withheld; and so it is that we ask for separate colony groups for these various types—colonies on the cottage plan, so that within the colony there may be classification of degrees of defect. Each colony must be complete in itself, entirely homogeneous, and quite distant from any of the other colonies on the reformatory grounds.

Treatment will start from the type standpoint. It will no longer be purely a moral-conduct readjustment problem, but predominately a medical-psychiatric treatment of conduct problem.

The next step, then in the correctional treatment of girl and women offenders is a new kind of reformatory—one that shall be organized and administered on the principle that the individual needs of the persons committed to it must be carefully studied; that individuals must be classified into proper and distinctly separated groups; that each group shall be given the special care and treatment that its members require, and that the care and treatment shall focus itself not only upon the physical problems involved, but especially upon the psychiatric problems which are the predominating factors in the delinquent careers of these women.

CHARACTER AS AN INTEGRAL MENTALITY FUNCTION*

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THE recognition of character as a major mental function in personality study is validated by the citation of a few simple psychologic considerations. Observation of the familiar but inscrutable phenomena of healthy mental functioning discloses the two essential, interdependent, inextricable components of mentality to be intelligence and character (moral force, stamina). Clouston says, "Above all it (psychology) must aim at providing a full and accurate account of those most fundamental elements of our constitution, the innate tendencies to *thought* and *action* that constitute the native basis of mind." (Italics are ours.) These are the essential means of expression for different, though blended or interacting, mental functions.

The next step in analysis refers these constituents to their respective functions in the "native basis of mind" and finds them to be intelligence and character. What logical conclusions may be drawn from the premise that intelligence is the primary function of thought and that character stands in the same relationship to action? The subjoined, tentative, categorical arrangement of some of the principal mental functions may assist in answering this question.

Outline of Mentality Study†

Mental Integrity
Mental Disorders
Mental Functioning in
Mental Health
Mental Diseases } (manifest in symptoms)

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† In devising and adapting this tentative working scheme, grateful acknowledgement is accorded Major A. J. Rosanoff of Kings Park Hospital for his "Classification of Mental Diseases" and Dr. Walter E. Fernald, Superintendent and Director of the Psychopathic Clinic of the Massachusetts School for the Feebleminded, for his "Fields of Inquiry" under Intelligence Deficiency.

Fields of Inquiry:
- Physical Condition
- Heredity, Environment
- Constitutional disorders
  - Recoverable psychoses
  - Recurrent psychoses
  - Chronic psychoses without deterioration
  - Chronic psychoses with deterioration
  - Epilepsy
  - Huntington's chorea
- Disorders of exogenous origin
  - Traumatic psychoses
  - Alcoholic psychoses
  - Syphilitic psychoses
- Other groups
  - Senile psychoses
  - Arteriosclerotic psychoses (non syphilitic)
  - Brain tumor
  - Cretinism and myxoedema
- Disorders of uncertain nature or etiology

Mental Functioning in
Intelligence Integrity / Intelligency Deficiency } (manifest in decisions)
(in terms of mental level or I. Q.)

Fields of Inquiry:
- Physical Condition
- Heredity, Environment
- Volitions, Inhibitions, Motives (selective)
- Habits of thought, Reason, Judgment
- Memory, General Information
- Association of ideas, Initiative (planning)
- Scholastics, Religious Training
- Foresightedness, Perception
- Apperception, Description, Imagination, etc.

Mental Functioning in
Character Rectitude / Character Deviations } (manifest in behavior)
(in terms of variety and degree)

Fields of Inquiry:
- Physical Condition
- Heredity, Environment
- Volitions, Inhibitions, Motives (operative), Instincts
- Habits of Action, Disposition
- Temperament, Emotionality, Sensibility
- Impulsiveness, Initiative (action)
- Adaptability, Fortitude, Egotism, Honesty
- Altruism, Control, Patriotism, Conscience
- Loquacity, Attention, Suggestibility
- Reactions to opportunity, competition, etc.

For the purposes of mentality study, intelligence may be conceived as the thinking, inventing, selecting, combining, planning, deciding function of mentality and character as the complementary mental function. Character then, is the emotivating, feel-

ing, sentimental, instinctive, sustaining, energizing, executing or vetoing function of mentality, and as such it is integral. Intelligence being the directing factor is responsible for its own product—decision; and character being the energizing force is responsible for its own product—action. Habit is a factor in both these functions, but a controlled factor i. e. it may be influenced by the will. Volition and inhibition, though under direction of intelligence, owe their force to character. Sentiment, emotion and conscience are related to character rather than to intelligence, and both the latter are inseparable parts of one whole—mentality. If intelligence be regarded as the judicial department of the mind, then character is as truly the executive.

An appeal to a person who exhibits inordinate emotionality to exercise control is sometimes, though mistakenly, made in a way to indicate that the intellect is at fault. In reality the appeal is made to the power of control—character, not to the knowledge of the importance of control—intellect. Appreciation of the importance of control is swept aside, if involved, by the action of the emotional force—character, counteracted more or less effectively by the power of control—character, again. Intellect apprehends and connotes the ideas rousing emotional reaction and suggests control of expression; but character yields expression or inhibits it. One in pain stoically refrains from screaming not because he knows it will do no good to scream, but because his character enables him to repress his screams consciously—or allows him uncontrolled expression in spite of his knowledge. Intelligence is not responsibly involved in either the triumph or defeat of the scream impulse.

Character force makes for efficiency of personality not less than does intelligence superiority. In fact, of the two, character is the valid determinant of personality behavior; since what is done is more potent than what is planned. A mentality able to plan well but in which execution fails or is faulty, is inefficient or malefficient and may be regarded as showing character deviation or anomaly. The soldier ordered into an imminently fatal action may have a superior intellectual equipment which appreciates both the command and the sacrifice involved in obedience; but that in his mental make-up which enables the sacrifice and energizes obedience—or inhibits it—is something other than intellect; namely, his character, the resultant of his innate endowment plus his training.

The reference of responsibility for decision and action to intelligence and character respectively is not an exclusive dogmatic division outlining distinct provinces, but a categorical reference for clarity of thinking and is comparable with other psychologic distinctions and references. That this reference is practically demonstrable is seen when the trusted bank employee embezzles. His character deviation is the occasion of his failure notwithstanding his repeated decisions not to steal; and his character deviation is blamed by his own intelligence and character and that of the court for the act. That the actual cause of failure is to be found in intelligence does not relieve character of the burden of responsibility. The cause of a gunshot is the powder ignition of which the indirect cause or occasion is the trigger pull. But responsibility is referred to the trigger pull, the occasion of the explosion.

Whether rightly or wrongly the fact remains that the fundamental idea of punishment and amenability to the administration of justice is that of teaching the importance not essentially of selecting behavior wisely but of wise performance. No attempt has ever been made to *enforce* better thinking and deciding, only to induce it as a means to the end of better behavior. The enforcement of acceptable behavior, however, is and always has been the fundamental purpose of civil and criminal jurisprudence. This places behavior under control of volition, i. e., acting or executive volition rather than selective or judicial. Instinct and reason have always taught that responsibility rests proximately with the acting province of mentality and with the thinking province only remotely. In actual daily usage one may think whatever he pleases, so long as his acts do not contravene established legal or social forms. When an offender is of demonstrably limited responsibility because of intelligence defect, there may be judicial clemency; but when he is demonstrably deviate in character only, there is no clemency, only the more sternness. The law imputes responsibility then, not for the selection of acts, but for their performance and in so doing tacitly recognizes something which we have termed character deviations as susceptible of improvement, in effect, demanding an approach in behavior to that emanating from character rectitude.

Current popular evaluation of personality is not confined to an estimation of intelligence only. Character is consciously or unconsciously regarded not less consistently, as the measure of

excellence and efficiency. We actually demand certain character standards or at least social behavior standards in the personalities selected for various activities; in employees, soldiers, business and professional men and especially in all teachers, statesmen and moulders of public opinion. To illustrate the distinction between these two functions in our thinking: we respect the loyalty of the feebleminded mother to her children when it is exhibited; but we deplore her inevitable neglect of their welfare. It is not the intellect but the character of our efficient enemy in Germany, that we despise. And to carry our illustration one step further: while it is our own intelligence that dictates our instinctive contempt for the Kaiser's principles, the dictation would be void without our character to express and enforce it.

No demonstration of the fact is needed that character development and deviation progress far beyond the close of the formative period of normal intelligence development. Thus the two are not coextensive. This is true also to a limited extent in cases of arrested intelligence development. In these cases character development or deviation is not wholly circumscribed by the deficient intelligence; though by no means independent thereof. Character modifications continue to be reflected in behavior after intelligence development ceases. Furthermore, it is to be observed that in the earlier years of the formative period which we have been accustomed to regard as terminating at about the age of twenty, character formation lags behind the normal development of intelligence; while in the later years of the period the developmental progress of character is much more pronounced and significant, outstripping and overshadowing the progress of intelligence in the evolutionary years at and after the close of the formative period. Studies of feeblemindedness in physical childhood are concerned with intelligence rather than with character. Personality studies of adolescents and adults on the other hand find the more potent and significant factors to be character or social behavior deviations. The child is not held to strict accountability for behavior since character is not yet sufficiently developed; while the adult is responsible unless the intellect can be arraigned. The reason for the observed failure of "Mental tests," adapted to childhood mental ages, to prove adequate to the classification of adult feeblemindedness, doubtless lies in the transcendent potentiality of character factors in the later developmental period.

It is conceivable that cases of a physical age well within the formative period of an intelligence capacity not far short of integral could largely overcome the effect of certain character deviations and build up a more nearly ideal character. In fact, our sometimes well founded confidence in the reformation of certain criminal cases finds herein its justification. And it may be found that the inexplicable economic success of certain cases apparently hopelessly handicapped by feeblemindedness becomes clear on the appropriate distribution of the handicapping factors between the rudimentary intelligence and the still developing character.

Character anomalies or social behavior deviations have been recognized as within the purview of psychiatric observation in personality studies; though they are not yet susceptible of measurement ("behavior disorders," "character defects" and "asymmetries"). Both intelligence defects and social behavior anomalies, however, lend themselves to recognition, classification, description and treatment. That which is clearly recognized and differentiated as an integral factor, though a complex one is the more readily outlined, described and measured. Many attempts have been made to discover a metric treatment for certain mental forces or elements, some of which we have included under character as a major mental function. Should the recognition of character as a major mentality function contribute to hasten the discovery indicated, that alone would be a sufficient *raison d'etre*.

For the purposes of a community survey, mental functioning in character deviations may be treated as on a parity with both that in intelligence deficiency and that in mental diseases as fields of mentality investigation, since each in its own province contributes to defeat and accelerates the tendency to dependency, though not necessarily equally. Neither bears a part-to-the-whole or inclusive relationship to the other. By neither character rectitude alone nor intelligence integrity alone may the personality achieve entire efficiency. The juxtaposition and contrast of these two of the three fields of personality study enable ready consideration and correlation of decision and behavior, essential indices in their respective fields of intelligence and character. Moreover, the ready categorizing is possible of instincts, clearly not an intelligence function with other contributory and subsidiary fields of inquiry: e. g., selective inhibitions, initiative, reason, etc.

This conception of mentality and its inherent nomenclature makes for simplicity and clarity, since it enables the more clear definition or elimination of certain "ill-defined terms," e. g., psychopathic personality, constitutional inferiority, etc., which we have used while deprecating the necessity. The reason these have been unsatisfying is that they represent a symptom complex made up of factors from more than a single entity. These hitherto convenient and indispensable concepts may be replaced in case reports of healthy mental functioning by measurements of intelligence deficiency and by citing character deviations with their observed varieties and degrees. This procedure is conducive to a more searching analysis and a more incisive discrimination, since the essential functions of thought and action are categorically separated, and therefore hardly to be confused in case studies.

Innate intelligence defects are not remediable, though subjects of such make some slight improvement under favorable conditions and are in many cases capable of acquiring a certain proficiency in simple occupations under efficient direction. Character deviations on the contrary are at least susceptible of improvement under the direction of intelligence. Consequently, the recognition of certain fields of mental functioning, e. g., honesty, veracity, fortitude, as belonging in the province of character broadens the outlook for the substantial advance of certain cases toward character rectitude.

Psychiatry in a narrower sense deals primarily with mental diseases; but psychiatrists are daily distinguishing between cases of mental disease and cases of intelligence defect and are noting character anomalies. In these activities they are promoting social and mental hygiene as a definite aim. The suggestion is that this broad sociologic purpose of psychiatry as well as the intrinsic considerations of scientific accuracy will be better realized by recognizing character and its subsidiary mental functions as an integral field for investigation. The psychiatrist finds in behavior an indispensable element in the estimation of the sociologic menace of feeblemindedness in adult cases. In fact, whether from the viewpoint of legal status, sociologic efficiency, medical classification or popular evaluation, the determination of feeblemindedness in physical ages above childhood considers character, categorically or otherwise, not less certainly than intelligence.

Fields of inquiry which we have placed under character have been distorted occasionally into the province of intelligence, since

they could not be ignored. Psychiatrical case summaries almost universally contain notations of character deviations, but hitherto these have seldom been made on their own merits. The point is that, since social behavior deviations are noted, clarity is more certainly secured by treating them as subsidiary to their appropriate major function. It is not the study of behavior and the notations thereon which have been neglected, but the recognition of character as an integral mentality function.

Certain cases reported in the following pages show intelligence to have been at least integral or of adult level in which character deviations stand out conspicuously as the predominant, if not the sole, cause of failure.

. . . . . .

Healthy mental functioning has two products or forms of expression—thought and behavior. Reference of these expression forms to their respective sources reveals intellect and character to be the mental functions involved.

Citations:

"Innate tendencies to thought and action . . . . constitute the native basis of mind."

Responsibility is referred to behavior rather than to intention or planning. This tacitly recognizes that which we have called character as integral.

Character as the immediate determinant of adult behavior makes for personality efficiency not less than does intellect.

Instincts, emotions, conscience and sentiments are subsidiary mental functions referable to character rather than to intellect.

The intellect dictates control of emotional expression while character exerts such control—effectually or ineffectually.

Intellect and character are synchronous in mentality development, but are neither coincident nor coextensive in either time or rate of development. Their relative importance is inconstant at any age level.

Personality studies of those of childhood physical ages are concerned less with character than with intellect since the former is then relatively rudimentary; but personality studies of adolescents and adults consider character the more intently as its dynamics increases.

Innate intelligence deficiency is stationary and irremediable, while character deviations are theoretically susceptible of correction while plasticity remains.

The recognition of character as a primary mentality function makes for clarity in psychiatric case study and terminology, and may perhaps hasten the discovery of methods of metric treatment.

Sociologically, a personality is more inimical whose character deviations are grave than is one which exhibits a grave intelligence deficiency.

In psychiatry and sociology as well as in legal and popular usage character with its subsidiary fields is immanent in personality evaluation both objectively and subjectively.

The eugenic and sociologic aspects of a population survey are more intimately seen, more clearly apprehended and recorded and more transparently represented when character deviations are recognized as an integral categorical entity.

What are the actual medical and sociologic results in the study and treatment of cases to be occasioned by the recognition of character and its deviations or anomalies as a major field of investigation in personality study?

Thus far our presentation has been an attempt to recognize psychonosologically the capacity for improved behavior observed to characterize certain groups of antisocial or dependent personalities. These groups will, apparently, comprise those of a sufficiently well equipped intellect to respond to an appeal to reason and self interest and to judicious training, i. e., those whose character is not beyond amendment. Such groups would include roughly, adolescent and young adult offenders, and dependents not mentally diseased nor deficient of the mental level of moronity. Most of these are not now in public institutions and none are to be found in schools for the feebleminded, e. g., young hoodlums and thieves, prostitutes, shiftlings, those of school age but neither in school nor at work. Some are in institutions, of course, such as orphanages, industrial schools, children's homes, reformatories, etc. Most members of these groups have missed a good or even fair home training, often because of disorganization of the home by death or divorce or desertion of parents or by parental neglect due to feeblemindedness. Each of these children has an individual sociologic problem that will hardly be solved without psychiatrical help. They are our potential criminals, prostitutes, malcontents and vagrants. The points to be noted are two: that these cases are salvable to economic productivity before character formation is complete and that propaganda for restoration would best be directed to character reformation.

That this vitally important sociologic need has been recognized by students, by public opinion and by legislation, and that the possibility of meeting the need has been popularly felt, is amply attested by the establishment of reformatories and special schools for such of the group as have become offenders. The methods and means hitherto applied have not been adequate for the task, however, partly because of delayed diagnosis and partly because of delayed remedial measures; but recognition of this fact and also of the allied facts that character deviations exist and that the possibility of correction of remediable character deviations, at least,

rests on a sound scientific basis will go far toward pointing out effective means and methods. Psychopathic laboratories would not be needed inside penal and eleemosynary institutions if they were available outside thereof, where ready access might be had under favorable conditions through field investigators to the rather large numbers of potential offenders who might be not only prevented from actually offending but who, by the same process, might become productive social units. A very real need for authoritative psychiatric differentiations and determinations is keenly felt by charitable associations, childhelping agencies and public school teachers dealing at first hand with defective delinquents and backward children in all the many states without such an organized scientific institution.

The same urgent demand for mental hygiene which prompts the scientific organization of existing psychiatric agencies for the elimination of psychopathic menaces from among recruits and for the induction back into industrial activity of our returned veterans surely suggests the salvage of the salvable portion of these groups of potential dependents. The exigencies of the war have advanced by many years the time when this comparatively young country would have urgent need economically for methods of diminishing her dependents. But we of this generation find this onus suddenly thrust upon us. The relative numbers of dependents at home and at the front stands far differently from the ratio of even one year ago. It is idle to speculate with no basis of facts; but if each family head were a producer for four dependents public and private before the raising of our army, we may think of him as called upon to provide for at least three times as many now, counting the immense cost of maintenance at the front and the sums we contribute to the relief of our war sufferers. Such of the salvage suggested as is undertaken in this generation must obviously be in the hands of those remaining at home.

The need for psychiatric laboratories and for psychiatric staffs in states and municipalities where public institution heads may avail themselves of expert advice and correct diagnosis on cases urgently needing judicious social and economic disposal and characterologic treatment is now keenly felt not only by physicians, but by laymen also. The field so admirably covered by our Boston Psychopathic Hospital and other Massachusetts psychopathic clinics has been of inestimable value in educating public

opinion to this need and to the availability of a scientific means of supplying it. Massachusetts is the leading state to act on definitely formulated plans to assist responsible deviates and the mentally disordered, as well as diseased, back to usefulness. Maine and other states look to the Psychopathic Clinic at Waltham and to other Massachusetts clinics as models, and are already canvassing the possibilities of establishing like institutions.

This field is open to psychiatrists pre-eminently since they are competent to differentiate mental disorders from the mental diseases encountered. Furthermore, they, especially are well equipped in methods, experience and trained personality to interpret and treat remediable character deviations. The community needs the nice discrimination, the exquisite psychiatric skill which distinguishes psychaesthenic and psychaesthetic states, but it needs also and especially in these days of war stress and necessity for conserving man-power, the devotion of our trained energies at home to the practical and not less scientifically worthy endeavor to relieve the next and succeeding generations of that part of the burden of dependency which is preventable.

Psychiatrists have a certain popular misconception to correct. The public is irked by the burden of dependency. Avoidable dependency is almost wholly due to intelligence defects, preventable largely in one generation and for those that follow, and to character deviations, partly remediable in this generation. These two classes are included among those popularly called feebleminded; but the popular mental picture is that of the idiot and imbecile. Our field of remediable cases includes none of these, of course, but is made up of those of a mental level no lower than that of moronity. The public has a right to know that a part of what has been hitherto called feeblemindedness, and not incorrectly so named, is in the higher grades preventable and remediable.

When it is understood that a considerable fraction of our dependents are really improvable in behavior and salvable by character training, the public will be ready to provide for such training. The cases to be included do not appear at hospital clinics and do not generally regard themselves as cases; but such could be found in numbers by the field workers who would form an essential part of such a psychiatric organization as would be competent in each state or municipality to deal with this class. The two mentally hygienic purposes to be realized then are (1) to deny

parenthood to the unfit and (2) to assist our high-grade dependents to build a more worthy character and become economically successful. Provision for these measures would also adjust that rather anomalous position in which society is still placed when intellectually incompetent persons are sentenced to a reformatory or other penal institution without a psychiatric examination. The question now being worked out in some states, e. g., Ohio, of maintaining a central clearing house of entrants to public custodial institutions would be automatically taken care of also, since the state psychiatric staff would perform that function.

Appendix

Two abstracts of cases are submitted, illustrative of the wider-angled presentation form of summation, enabled by the recognition of character as a categorical entity in mentality study.

Case No. —

H. is a fairly well developed girl of 15.9 years, definitely ascertained. She consistently maintained that her age was thirteen. Skin shows fine superficial acne and lacks good color. Her mental attitude is rather listless and lacking in spontaneity and responsiveness. Of her father she apparently knows nothing. Of her mother she reports her death when H. was three. Of her siblings and collateral relatives she apparently knows nothing and conveys the impression that she lacks interest. She was cared for as a state charge or in a family in childhood till she began school at about the age of seven. In school in Oakland she repeated no grades but was regularly advanced till she attended a high school for a year. She left school on her own initiative to begin housework, having worked for her board while attending school. During this experience she was discharged for theft.

This fact she was very slow to admit and would have allowed an incorrect reason for this change of residence to be recorded. No place was held by her more than a few days after this, and she became dependent on the Maine Children's Home Society, at Augusta, an institution that had several times placed her, apparently favorably.

Menstruation began at the age of eleven. She denies transgression, but admits understanding the meaning of sex intercourse. She admits being out evenings with girls and boys and that sometimes a boy and girl went off by themselves, but adds that she never did this.

On the day of the examination it is learned from her guardian that she begged for permission to answer a letter to a boy in Waterville, ten miles away, saying she must answer it; but she would give no valid reason. Refused, she canvassed the possibility of walking to Waterville to see

him. The snow of an exceptionally severe winter was piled impassably high. Then she sought permission to write to a girl friend whose reputation in sex matters is bad. This being reluctantly given on her representation that she *must* write her; she apparently prepared the letter. As the rural delivery man appeared she slipped out to the country road through the deep snow and gave him a letter reporting on her return that she had posted the letter to her girl friend. This roused suspicion and her effects were searched revealing an unfinished letter to the girl. In the letter was found about a foot of gold chain recognized by the guardian as her own (the guardian's).

Under H.'s pillow that morning had been found too, a piece of black lace that the guardian identified as her own (the guardian's) and which must have been taken from the depths of a trunk in the attic to which H. was not supposed to have access. Furthermore, a dime which H. had seen left in a vest had been missed. When inquiry was made of H. anent these items she vehemently denied one after the other, "Honest to God" she had not seen the dime, knew naught of the lace, etc.

When tested she showed very good scholastic ability, computing interest mentally. Her general information was rather remarkably good. She could attend well and showed quick penetration and grasp and readily drew correct academic conclusions; but she became silent whenever a disagreeable admission was called for. Her reluctant admission could be at length elicited; but not so long as she could see any escape by evasion. She volunteered nothing except in excuse or extenuation, e.g., after several specific admissions of theft had been won from her she volunteered "I can't help stealing," and again, "I steal things I don't want." "Have you ever been tempted to steal something when you have decided not to steal and have walked away leaving it?" "Yes I have." "Well, does not that show that you can avoid stealing when you really try your best?" She hesitated long before answering in the affirmative, meanwhile admitting and showing she understood the logic of the situation. "Would you not blame anyone who steals from you?" "Yes." "Does not the law hold anyone who steals punishable?" "Yes." "Well, aren't you to blame if you steal then?" Again she very reluctantly admitted her responsibility. At one point she volunteered that she never had stolen money. When she was told that the examiner probably ought not to believe that, as it was so unlikely that anyone who had stolen as she had done would refrain from taking money, she at length admitted she could not blame the examiner for declining to believe that statement. The distinction between telling her she could not be believed in a certain statement and calling her a liar was appreciated and admitted readily.

She resisted the suggestion for sometime that her life was one of failure more than success because of her thefts and lying, but at length admitted it. Then she resisted the suggestion that she could change all

that and live a happy and successful life if she would try hard enough. No satisfactory reaction could be elicited to this, no smile or hopeful attitude, though at the time this suggestion was made her admissions were all in, her fencing had ceased and she was quite at ease and thinking clearly on the subjects suggested.

Findings:

Mental disease: none.

Intelligence: mental age level, 15; I. Q., 1.; category, normal or adult. Capacity for abstract reasoning poor even for her age, but when stimulated her conclusions are valid. Foresight and planning are very illy developed.

Character rectitude or deviations: principally in the emotional sphere and exhibited in habitual theft and lying. Reactions to altruistic, patriotic and filial regard stimuli lack development. Reaction to considerations of self-interest is weak. Insight is poor. Impulse is the principal guide to action and capacity, for self-denial is small. Voluntary control of expression is habitually that of dissembling and, impulsive egotistic *sang froid* is consistently maintained.

Sociologic maladjustment: criminal tendency, dependent child.

CASE NO. —

American-born, age 21–3, of naturalized German parentage. Attended Bridgeport schools from 7 to 15, more than half time, repeating four grades, one of them twice. Was out for sickness; heart trouble of which he has none now. Truancy not a large factor. Father died of paralysis five or six years ago. Mother is living. She was at a sanitorium three months on account of being "run down." Lost her memory and could not care for her household. History of collaterals is negative for institution residence and dependency. Sister is a widow at home with mother and brother who is a carpenter—a family with no margin of safety.

S. was married soon after the age of twenty-one to an imbecile after having been balked in several attempts. He admits gonorrhea while in the army four months whence he was honorably discharged as mentally unfit. He handled fractions well and denominate numbers and knew how to attack simple interest. His general information was good. His answers were prompt and though at times tending to be flippant and evasive he readily adjusted his attitude on a warning. He uses tobacco, but denies the use of drugs and alcoholics. Physically, he is well nourished but musculature is soft. There is a mild conjunctivitis. Forehead is both low and narrow; teeth are crowded and irregular. Clothes are dirty. House is poorly furnished and is unpainted and illy repaired, but is swept and fairly orderly. S. was found sitting in house idle with

wife and her eight-year-old sister. He resisted the suggestion that these are remarkably favorable times for working men and would have loquaciously taken over the interview at this point, at others also. His chief interest was in excusing, exculpating and inveighing against those who extended no help and sympathy. He claimed to have walked three miles and back in an unsuccessful hunt for work on the preceding day. He resisted the suggestion that he made a mistake in leaving school and neglecting a trade, also the suggestion that he would have done better to stick to the $2.50 a day he was getting before he joined the army. A search for motives for joining the army elicited no suggestion of anything more worthy than self-interest and the stress was on his feeling "he wanted to go." To the suggestion that he now had the responsibility and burden of a wife, he again took the superficial view, saying she was as well off as before her marriage. He was a little disturbed but not resentful that the army examiners had found him "deficient mentally." Denies arrests.

Mental disease: none.

Intelligence: mental age level, 15; I. Q., .90; category, adult, but judgment is poor.

Character rectitude or deviations: shows various anomalies, e.g., lack of action for self-support, due in part to lack of appreciation of the worthy motives for so doing. Capacity for self-denial is small. Altruism and patriotism are not in evidence. Ambition is undeveloped. Love of ease and gratification are too ascendent.

Sociologic maladjustment: potential dependent.

NOTES AND COMMENTS

Illinois

The Department of Public Welfare, in conjunction with the Board of County Commissioners of Cook County, opened the Juvenile Psychopathic Institute at the Cook County Psychopathic Hospital, on December 18, 1917. A voluntary consulting service has been inaugurated designed to offer free consultation with physicians, psychiatrists, psychologists, social workers, probation officers, judges, occupation and employment workers and others, to all who may apply.

The work of the service includes (1) examination for feeblemindedness, (2) examination of incorrigible or truant cases, or those showing other signs of misconduct likely to prove dangerous to themselves or to the community, (3) after care and follow-up work of juveniles who are on probation, or otherwise assigned to the Institute by the court, or who are on parole from the State Schools of St. Charles and Geneva, and the State Reformatory at Pontiac. This branch of the work will be carried out in co-operation with the state parole officers, the probation officers of the various courts, and the social agencies of Cook County.

Two wards have been set aside at the Psychopathic Hospital for the institutional observation and treatment of juvenile psychopathic individuals. These wards contain twelve beds each, one ward for boys and the other for girls. No child may be kept longer than ten days. Children may be admitted voluntarily, at the request of parents or guardians, through court order of the County or Juvenile Court, and by transfer from the Juvenile Detention Home.

The work of the Institute includes medical and psychiatrical examination, psychological testing and social investigation. The work is conducted as an out-patient department, applicants coming at will or by appointment, and receiving a preliminary examination. When more extended examination is necessary, or when observation is desirable, the children are admitted to the wards set aside for this purpose.

Maine

The Augusta State Hospital is about to establish in Portland a clinic for mental and nervous disorders. Suitable accommodations have been secured in the City Hall, and the clinic will be held once each week from 10 a. m. until 4 p. m., on Wednesdays.

The sole object of the clinic is the conservation of mental health, and it is hoped that physicians will refer their mental cases for consultation, that organized agencies having mental or difficult cases will avail themselves of it, and that all persons feeling the need of advice or examination will feel free to present themselves.

Massachusetts

Chapter 142 of the Acts of 1918, approved April 12, and effective upon its passage, providing for the temporary care of persons in the military or naval service of this country suffering from mental disease, reads as follows:

"Section 1. The superintendent of any state hospital for the care, treatment or observation of the insane, and the McLean Hospital, may receive for care and treatment any person in the military or naval service of the United States who is suffering from mental disease and cannot properly be cared for at the army post or naval station or hospital where he is stationed or happens to be, upon the written application of the medical officer in charge of such post, station or hospital, who shall make a full statement of the case in such form as may be prescribed by the commission on mental diseases. Unless otherwise ordered by the proper military or naval authority, persons received into a hospital under the provisions of this act may be detained therein for a period not exceeding sixty days, except that further detention, if necessary, may be authorized by the commission on mental diseases.

"Section 2. The commission on mental diseases is hereby authorized to make contracts with the federal government relative to the support of persons received and cared for under the provisions of this act on such terms as may be agreed upon."

New Jersey

A new board of Charities and Corrections has been created under Chapter 147, Laws of 1918. This measure is the direct result of the recommendations made by the Prison Inquiry Commission and the Charities Inquiry Commission appointed by the Governor to investigate the institutions in the state.

The board is to have control over the charitable and penal institutions of the state, and is charged with establishing broad lines of policy for their development. It is also to have supervision, with the right to visit and inspect, all county, municipal and private institutions receiving state aid. This board is authorized to appoint a commissioner to be its chief executive, whose salary is not to exceed $10,000 a year. The board also has the power to create a division of medicine and psychiatry, one of education, one of labor and agriculture, one of statistics, one of parole, one of food and dietetics, and any such other divisions as it may deem necessary. This law among other provisions states that any person suffering from insanity or alleged to be insane shall not be committed to or confined in any unlicensed private institution in the state for the care and treatment of the insane.

This law also makes provision for the admission and commitment of the insane epileptic, tuberculous and feebleminded to the several institutions devoted to their care.

The following provision for voluntary admission to hospitals for the insane may be of particular interest:

"Any person resident in this state believing himself about to become insane or in danger of losing his reason, and being desirous of obtaining treatment for the betterment of his mental condition, may be admitted to any public institution for the care and treatment of the insane in this state by filing with the chief executive officer thereof, at or before his admission, an application in writing to be approved and furnished by the board of managers or the board of chosen freeholders, as the case may be, setting forth his name, place or places of residence, for a period of ten years preceding such application, and a full statement of his financial ability to support himself, or the financial ability of the person or persons chargeable by law with his support, together with such other information as may be required on the forms approved and furnished as aforesaid. It shall be the duty of the chief executive officer to forward forthwith a certified copy of such application to the commissioner in lunacy of the county from which such patient is admitted, who shall investigate the matter of legal settlement and indigence of such patient, and the person or persons chargeable with his support, and report the facts to the proper judicial officer of such county, who shall make a legal finding as to the legal settlement and the financial ability of the patient or the person or persons chargeable with his support as aforesaid, and shall have the right to make an order for the payment of the whole or any part of the costs and expense of the care and maintenance of such patient, as in the case of involuntary commitments. Such finding shall be filed in the same manner as final orders of commitment are filed."

The law also provides that "if any person in confinement under commitment, indictment or sentence, or under any process, shall appear to be insane, epileptic, imbecile, or feebleminded, the justice of the Supreme Court presiding in the courts of the county in which such person is confined, or judge of the Court of Common Pleas of said county, may, upon presentation to him of the application and certificates hereinabove provided, institute an inquiry and take proofs as to the mental or physical condition and legal settlement of said person in the manner and form hereinbefore provided, pending which inquiry such person may be temporarily confined in an appropriate public institution in this state, upon an order of such justice or judge; and if said justice or judge shall determine that said person is insane, epileptic, imbecile or feebleminded, he shall order that said person be removed from imprisonment, and that he be confined in one of the institutions for the care and treatment of such persons owned by the State of New Jersey, or if said justice or judge shall deem it expedient, in an institution for the care and treatment of such persons owned by one of the counties of this state, until said person is cured or removed or discharged according to the law."

New York

The New York State Prison Commission appointed at its last monthly meeting a Committee on Mental Disease and Delinquency which has begun inquiries to enable it to outline legislation for the state to provide for psychiatric facilities for the state penal and reformatory institutions. This action was taken following a resolution adopted by the Commission endorsing psychiatric work among prisoners.

At a meeting of the Superintendent of Prisons of the State of New York with the prison wardens and physicians, on July 12, 1918, a committee was appointed to outline measures for continuing the Psychiatric Clinic at Sing Sing Prison, and for extending the work to the other prisons of the state.

In accordance with chapter 197, which became a law April 13, 1918, Dr. Walter B. James of New York City has been appointed Chairman of the State Commission on Feebleminded. The men who will serve with Dr. James are the Fiscal Supervisor of State Charities and the Secretary of the State Board of Charities.

The duties of the commission are as follows:

1. To administer the law in relation to the custody, care and treatment of the feebleminded.
2. To take a census of all feebleminded.
3. To provide and keep a record of all feebleminded persons in the state, and to provide accommodations for all that require care and treatment in a suitable institution.
4. To prepare and recommend to the legislature by February 1, 1919, a commitment law for the feebleminded.
5. To provide for establishment and operation of clinics for the examination and observation of feebleminded persons.
6. To provide for the establishment of farm and industrial colonies.
7. To make regulations for the reception, care, training, parole and discharge of inmates of institutions for the feebleminded.
8. To direct the transfer of inmates from one institution to another.
9. To make a report annually to the legislature, giving an account of its proceedings, facts necessary for the information of the legislature, a statement of the capacity of each institution and an estimate of the number of additional beds required for the ensuing year.

The act carries an appropriation of $25,000 and became effective July 1, 1918.

Chapter 639, which became a law May 13, 1918, creates a department of narcotic drug control, the head of which is the commissioner of narcotic drug control. He is appointed by the governor, with the advice and consent of the senate, for a term of six years, at a salary of $6,000 a year. He may appoint three deputy commissioners at a salary of $3,500

each, and also a secretary, who shall also act as financial clerk, to receive $3,000 a year. The commissioner may also appoint counsel and other employees that are needed. The department is to regulate the prescribing and dispensing of narcotic drugs. This law also provides for the commitment of addicts, and for their voluntary admission for hospital treatment. For the carrying out of the provisions of this act, the sum of $27,400 is appropriated, for the period of eight months ending June 30, 1919.

In September, 1916, a joint legislative committee was appointed, in accordance with a resolution passed in April, 1916, to investigate the laws in relation to the distribution and sale of narcotic drugs. This committee reported to the legislature in February, 1917, and at that time requested an extension of time to make a more complete investigation. This extension was granted, and the committee again reported in March, 1918. The law creating a department of narcotic drug control is the outcome of the study and recommendations of this committee.

Chapter 342, laws of 1918, provides for the establishment of a bureau of venereal diseases in the state department of health, and appropriates $30,000 for carrying into effect the provisions of the act.

The bureau is authorized to buy, manufacture and dispense, under conditions prescribed by the state commissioner of health, remedies for the treatment of these diseases, to examine specimens submitted, to make all necessary tests, to provide and distribute literature and to use such other means as seem desirable for the instruction of the public and the suppression and cure of venereal diseases.

South Carolina

Act 398, approved by the Governor on February 12, 1918, provides for the establishment of the State Training School for the Feebleminded. This institution is to be under the supervision of the Board of Regents of the State Hospital for the Insane, but is to be entirely separate from the hospital both in location and management. The Board is authorized to appoint an advisory committee of three women whose duties shall be to visit the institution at least quarterly and to advise with the Board as to the management of the school.

In accordance with the provisions of this act, feebleminded persons may be (a) admitted or (b) committed to the institution. "In granting the applications for admission, or in accepting the commitments, of feebleminded persons to the said Training School, the Board of Regents or the Superintendent, acting with such discretionary powers as are given him by this Act and by the Board of Regents, shall observe the following conditions: (1) No decree of any Court having jurisdiction under this Act, committing any feebleminded person to the said Training School, shall be binding upon the said Board of Regents until ac-

cepted by them. (2) Preference may be given to women of child-bearing age, and to the more trainable boys, girls and young men. (3) The Board of Regents shall prevent undue crowding of inmates in the said Training School."

"Applications for the admission of feebleminded persons shall be made to the Board of Regents of the State Training School in the following manner: First, by the father or mother, if the father and mother are living together; second, if the father and mother are not living together, then by the one having the custody of the child; third, by a guardian duly appointed; fourth, by the superintendent of any county almshouse, or by the person having the management of any orphanage or other institution where children are cared for; fifth, by the County Commissioners of any county or the County Supervisor in those counties which have no County Commissioners. In items three, four and five of the above, the consent of the parents is not required. It is further enacted that all applications for admission shall be submitted by the said Board of Regents to the State Board of Charities and Corrections before being granted. Thereupon, the State Board of Charities and Corrections shall investigate the application and report their findings with their recommendations to the Board of Regents of the State Training School for the Feebleminded. The said Board of Regents shall then, in accordance with such rules as they may make, determine which of these applications for admission shall be granted and in what order."

The procedure in the case of commitment is as follows:

A relative, guardian or any reputable citizen of the state may file with the Judge of the Probate Court or with the Clerk of the Circuit Court, a petition in writing, setting forth that the person is feebleminded, the facts and circumstances of the social conditions, or other causes, making it unsafe for the community for him to be at large without supervision, control or care; also the name and residence of the person caring for him, if any, and of at least one person, if any there be, legally chargeable for his support, and also, if known, the names and residences of the parents or guardians.

The hearing on the petition is by the court and a commission appointed by the court consisting of two qualified physicians, or one qualified physician and one qualified psychologist, residents of the state, appointed by the judge. The commission is to examine the person, and upon conclusion of the hearing and examination, the commission shall file with the court a report setting forth their conclusions and recommendations.

If the court finds that the person is not feebleminded he shall be discharged. If he is found to be feebleminded he shall be sent to the School provided for in this act.

For carrying out the provision of this act, $60,000 is appropriated.

Buenos Aires

A report of the state hospital for the insane, which covers a period of twenty-seven years, states that alcohol was responsible for the insanity in 39.6 per cent of the 28,035 patients during that period.

The Canadian National Committee for Mental Hygiene

The Canadian National Committee for Mental Hygiene, the second national agency of this kind to be established, was organized at Ottawa, April 26, 1918. In regard to its organization, Mrs. Colin K. Russel, in the June number of *The Canadian Medical Association Journal* says:

"Though much special work along many of these lines has been done in various individual groups in Canada, it is to Dr. Clarence M. Hincks, of Toronto University, that we owe the co-ordination of effort which has resulted in our new Canadian National Committee for Mental Hygiene. His was the vision which, having a keen appreciation of our needs in Canada, combined a power of organization with unusual energy and enthusiasm. Learning of the work of the National Committee of the United States, he set to work to rouse the public interest in the need for such a work in Canada."

Following is an abstract of the proceedings of the founding meeting of the Canadian National Committee for Mental Hygiene:

The business transacted at the founding meeting consisted of the adoption of a constitution, the election of officers, and the outlining of a programme for immediate work. In connection with the latter, Mr. Clifford W. Beers was called upon to give an account of the work of the (American) National Committee for Mental Hygiene, of which he is Secretary. Mr. Beers gave interesting information with regard to surveys conducted by the National Committee, and said that through such work improvement in the care and treatment of the insane had followed. He also spoke of the studies that are now being conducted at Sing Sing Prison, and stated that investigations into the psychopathology of crime would probably have a far-reaching influence in reforming methods of treating criminals. Mr. Beers referred to the work of the Committee in connection with the problem of feeblemindedness. He then emphasized the valuable war work that was being conducted, and pointed out that the National Committee had been instrumental in establishing a mental examination of drafted men in the American Army, and that on account of this step 15,000 men had been rejected because of mental and nervous disability. This would result, he said, in a tremendous financial saving to the United States and would be of incalculable value in maintaining a high grade of efficiency and morale in the army.

With the work of the (American) National Committee for Mental Hygiene in mind, and after considering pressing needs in Canada, the following programme of work was undertaken for the ensuing year:

1. *War Work.* A careful study of the problem of mental and nervous disease in the Canadian Army will be undertaken, and the way in which mental and nervous cases have been treated in England, France, and the United States will be carefully considered. Based upon these findings it is proposed to present recommendations to the proper authorities. In addition, the Canadian Committee will endeavor to assist the military authorities in finding personnel for military mental hygiene work, and will arrange, through Canadian universities, to have special courses of instruction provided for prospective workers in this field.

2. *Immigration.* It is proposed that the Canadian National Committee should make a comprehensive study of the problem of immigration in Canada, should advise itself concerning what has been done in other countries, particularly the United States, to exclude the mentally abnormal immigrant, and when such studies are concluded should make recommendations to the proper governmental authorities. This programme was adopted because it was known that probably 50 per cent of all the feebleminded and insane in Canada were foreign-born, and it was quite evident that the Federal Government at Ottawa had not in the past made satisfactory provision for the exclusion from the Dominion of mentally abnormal immigrants.

3. *Statistics.* The Canadian Committee will begin a statistical study of the treatment and care of the insane and feebleminded in the various provinces. Included in this department of work will be the collection of facts relating to the legal basis of state care; the history and present status of state care; the economics of state care; facts concerning state administration, supervision, and inspection; facts concerning state institutions for the feebleminded and insane; facts concerning commitment, discharge, and parole; social service in mental cases; psychiatry in medical schools, etc.

4. *Library.* The Committee will establish a library on mental hygiene, and will specialize, during the first year, on literature relating to war psychoses and neuroses, and immigration. It is hoped that the library will perform a useful function in collecting and distributing material in answer to requests for literature and information, in supplying material for lectures and lecture courses, exhibits, and general propaganda, and in supplying bilibographies for distribution.

5. *Research.* The Committee will endeavor to arrange for special investigations to be made in various parts of the Dominion. It was suggested that among other studies an investigation into the psychopathology of juvenile delinquency and prostitution would be exceedingly useful.

6. *Propaganda.* Arrangements will be made for lectures on mental hygiene in various centres of the Dominion during the coming year. In such cities as Montreal and Toronto several public meetings addressed by eminent American authorities will be held. In addition, members of the Canadian Committee will give addresses on mental hygiene from time to time, and pamphlets on the subject will be distributed.

7. *Contemplated activities that will be postponed until the second year.* (a) Establishment of provincial and municipal societies for mental hygiene. (b) Surveys of hospitals for the insane.

Before the meeting adjourned it was announced that $50,000 had already been subscribed for the work of the Committee, and the following resolutions were passed:

That whereas the (American) National Committee for Mental Hygiene has manifested a keen interest in the organization of the Canadian National Committee for Mental Hygiene by sending to Canada, its secretary, Mr. Clifford W. Beers, and by making a presentation of many copies of his book, "A Mind That Found Itself," that therefore this Committee express to the (American) National Committee its hearty appreciation; and that, whereas Mr. Clifford W. Beers has, through his splendid efforts during his visits to Toronto, Ottawa, Montreal, and Quebec, on behalf of the Canadian National Committee for Mental Hygiene, rendered the most valuable assistance in facilitating organization, stimulating interest in mental hygiene, and in securing financial support, that therefore this Committee place itself on record as acknowledging with the sincerest appreciation the help which he has given.

The following are the officers of the Canadian National Committee for Mental Hygiene:

Patron: His Excellency the Duke of Devonshire, Governor-General of Canada.

Patroness: Her Excellency the Duchess of Devonshire.

President: Lieut. Col. Charles F. Martin, M.D., Montreal.

Vice presidents: Lord Shaughnessy, Montreal; Sir Vincent Meredith, Montreal; Sir Lomer Gouin, Premier of Quebec; Sir Robert Falconer, Toronto; Sir William Peterson, Montreal.

Treasurer: Sir George Burn, Ottawa.

Executive Committee: Lieut. Col. Colin K. Russel, Montreal, Chairman; Dr. Peter H. Bryce, Ottawa; Prof. J. A. Dale, Montreal; Dr. C. J. O. Hastings, Toronto; Dr. W. H. Hattie, Halifax; Lieut. Col. Vincent Massey, Toronto; Major J. D. Page, Quebec; Dr. C. A. Porteous, Montreal; Prof. Peter Sandiford, Toronto; Lieut. Col. Charles F. Martin, Montreal.

Executive Officers: Dr. C. K. Clarke, Toronto, Medical Director; Dr. C. M. Hincks, Toronto, Associate Medical Director and Secretary.

In addition to the officers, the following representative men and women of the Dominion are also members:

Hon. George E. Amyot, Quebec
R. B. Angus, Montreal
Lord Atholstan, Montreal
Adam Ballantyne, Toronto
Capt. Gordon Bates, Toronto
E. W. Beatty, Montreal
Col. H. S. Birkett, Montreal
W. M. Birks, Montreal
Dr. A. D. Blackader, Montreal
Dr. Edward A. Bott, Toronto

His Honour Lieut. Governor Brett, Edmonton
Dr. Horace L. Brittain, Toronto
Dr. Brochu, Quebec
Dr. Allan Brown, Toronto
Dr. T. J. W. Burgess, Montreal
J. Burstall, Quebec
Hon. Thomas Chapais, Quebec
Dr. W. H. Chipman, Montreal
Mrs. P. D. Crerar, Hamilton
Dr. Winnifred Cullis, Toronto
Dr. F. E. Devlin, Montreal
Mrs. Arthur Drummond, Montreal
Mrs. D. A. Dunlap, Toronto
Lady Eaton, Toronto
Major J. G. Fitzgerald, Toronto
Mrs. J. G. Fitzgerald, Toronto
Sir Joseph Flavelle, Toronto
Mrs. W. L. Grant, Toronto
W. D. Gwynne, Toronto
Chief Justice Harvey, Edmonton
Dr. Goldwin Howland, Toronto
Mrs. A. M. Huestis, Toronto
Miss Hurlblatt, Montreal
Lady Kingsmill, Ottawa
Dr. Lachapelle, Montreal
Mrs. J. B. Laidlaw, Toronto
Sir Richard Lake, Regina
Judge Langelier, Quebec
Sir James Lougheed, Calgary
Dr. Helen MacMurchy, Toronto
C. A. Magrath, Ottawa
Hon. W. M. Martin, Premier of Saskatchewan
J. M. McCarthy, Quebec
J. O. McCarthy, Toronto
Mrs. Nellie McClung, Edmonton
Dr. R. E. McKechnie, Vancouver
Francis McLennan, Quebec
Mrs. McLimont, Quebec
Mrs. W. B. Meikle, Toronto
Lady Meredith, Montreal
W. R. Miller, Montreal
F. W. Molson, Montreal
Dr. Gordon Mundie, Montreal
Judge E. F. Murphy, Edmonton
President W. E. Murray, Saskatoon
W. F. Nickle, M.P., Kingston, Ontario
Sir Edmund Osler, Toronto
Dr. E. J. Pratt, Toronto
Sir William Price, Quebec
Rev. W. M. H. Quartermaine, Renfrew, Ontario
Miss Helen Reid, Montreal
Prof. R. G. Revell, Edmonton
Dr. Armour Robertson, Montreal
Bishop Roper, Ottawa
Frank W. Ross, Quebec
John Theodore Ross, Quebec
Mrs. Colin K. Russel, Montreal
Dr. Francis J. Shepherd, Montreal
Mrs. Adam Shortt, Ottawa
Mrs. Sidney Small, Toronto
Hon. George P. Smith, Edmonton
Prof. W. G. Smith, Toronto
Hon. Charles M. Stewart, Calgary
Rev. Dr. Symonds, Montreal
Madame Jules A. Tessier, Quebec
Hon. R. S. Thornton, Winnipeg
Hon. A. Turgeon, Quebec
Dr. von Eberts, Montreal
Miss Grace T. Walker, Toronto
Mrs. H. D. Warren, Toronto
Dr. F. F. Wesbrook, Vancouver
Hon. Smeaton White, Montreal
T. H. Wills, Hamilton
Capt. O. C. J. Withrow, Toronto
Major H. P. Wright, Montreal

Training School of Psychiatric Social Work

The opening of the Training School of Psychiatric Social Work at Smith College, Northampton, Massachusetts, on July 8 was an event of much importance in the mental hygiene movement. That the education of lay workers for the care of nervous and mental cases should have been undertaken by one of our distinguished colleges is significant of a growing change in public sentiment toward mental disease precipitated by sympathy for the so-called "shell shock" cases of the war. That the

course should be given under the auspices of the National Committee for Mental Hygiene through a committee of eminent psychiatrists is significant of the increasing disposition of physicians to consider the social involvements of mental disorders. The war emergency has focused influences that were already active. For several years, there has been a demand that could not be met for psychiatric social workers in civilian work, but no provision for training existed except apprenticeship courses such as the Department of Social Service of the Boston Psychopathic Hospital offered. The Director of this hospital, Dr. E. E. Southard, foreseeing an increased war demand for social workers so trained, secured by means of an appropriation from the Permanent Charity Fund of the Boston Safe Deposit Company the release of the Chief of Social Service, Miss Mary C. Jarrett, on part time for organization of war emergency courses. At the same time the National Committee for Mental Hygiene, facing the problems involved in the rehabilitation of soldiers returned suffering from nervous and mental disorders, was convinced of the need of training lay workers to assist physicians in the care of neuro-psychiatric cases, and a committee of which Dr. Southard was chairman was appointed to take up the matter. Meanwhile the probable demand for trained workers in this field had been suggested to Dr. Neilson, President of Smith College, at that time considering several types of war work for a possible summer school. A combination of these elements resulted in the present Training School, which gives an eight months' course, eight weeks of didactic work at Smith College followed by six months of practical experience in different hospitals and organizations.

The object of the course is to prepare social workers who shall be able to perform three functions if necessary, or any one of the three that may be required; (1) to secure social history essential to medical diagnosis by interview or correspondence with informants or by interviewing patients; (2) to assist the physician in psychotherapy by such means as encouragement, explanation, re-education; (3) to promote the social adjustment of patients upon discharge from the hospital. The students will be instructed in the technique of social case work both by lecture and practice. During the summer session, they receive instruction in psychology, including mental tests; sociology, including community organization and methods of social case work; and social psychiatry, covering the general character of nervous and mental disorders and including clinics at the Northampton State Hospital. Equally important as the knowledge gained is the discipline acquired in such a training school. An eight months' course in a subject that deals with so complex a matter as human personality must be recognized to be superficial at the best. The student, however, will be drilled in the fundamental habits of mind required for further development—a professional attitude, the psychiatric point of view, adaptability, the habit of observation.

The March number of the *Public Health Journal*, Toronto, Canada, is devoted to the subject of feeblemindedness. The following articles are of special interest: "The Work of the Psychiatric Clinic of the Toronto General Hospital," C. K. Clarke, M. D.; "The Problem of the Feebleminded," Marjorie Keys; "Mentally Deficient Children," Clarence M. Hincks, M. D.; "Psychology and Public Health," W. G. Smith; "Mentally Deficient Recruits for Army Service," Capt. O. C. J. Withrow, C. A. M. C.; "Hamilton Branch of the Provincial Association for the Care of the Feebleminded," T. H. Wills.

Dr. Clarke, after briefly stating the aim of the Clinic in its establishment, and noting the enthusiastic co-operation of the city health authorities, the juvenile court, and the board of education, offers statistical material of much interest.

From April 8, 1914, to February 1, 1918, of the 3,587 patients examined, 1,249 of those diagnosed as defective came from the juvenile court. There were found to be 862 morons, 818 imbeciles and 114 idiots. Of the total number examined only 322 could be classified as "probably normal." There were 448 cases of immorality, among whom were 218 mothers of illegitimate children. Although no general routine Wassermann test was made, 225 were found to be syphilitic. At the present time every case examined has a Wassermann test.

Dr. Clarke states that recently the number of morons coming to the Clinic has greatly increased, and he strongly advocates segregation of this class before they develop criminality. Of the patients coming to the Clinic, only 45.33 per cent are Canadian. From this fact Dr. Clarke concludes that the authorities have been negligent at the ports of entry, and urges a careful mental survey of immigrants.

The author points out the close relationship between prostitution, illegitimacy, feeblemindedness and venereal diseases, and recommends the segregation of defective prostitutes as an effective measure in helping to deal with the question of the increase of venereal disease.

The Venereal Disease Prevention Act of Ontario, Canada

"The following is a synopsis of an Act recently passed by the Legislature of the Province of Ontario with the purpose of controlling venereal diseases.

"The Act provides that any person under arrest may, if the medical officer of health believes that the person is infected with venereal disease, be required to undergo an examination in order to ascertain if he is, or is not, infected with this disease, which by the Act includes gonorrhoea, syphilis and chancroid. If the person so examined is found to be infected he may be detained and treated. Physicians in medical charge of gaols and other places of detention are required to report within twenty-four hours, any persons confined who may be found to be infected.

"If a medical officer of health has credible information that any person is suffering from venereal disease the officer may require such person

to be examined, and if the person is infected the officer may take steps requiring satisfactory treatment.

"In order to prevent unjust action against a physician who makes an examination or report in respect to such cases, it is provided that such action can only be brought with the consent of the Provincial Board of Health.

"Provision is made for right of entry to a house or premises by the medical officer of health or his deputy in the daytime for the purpose of inquiry or examination in respect to such cases. This provision is identical with the one in force in respect to other communicable diseases.

"Hospitals designated by the board are required to provide facilities for treatment.

"No one but a legally qualified physician is allowed to attend upon or prescribe for or supply or offer to supply any drug, medicine, appliance or treatment to or for a person suffering from venereal disease or for the purpose of the alleviation or cure of such disease; the only exception to this being that a qualified chemist may fill the prescription of a physician for such purposes. The penalty for infringement of this provision is $100 to $500. A similar penalty is provided against advertising in a newspaper, pamphlet or other periodical, any remedy or cure for these diseases. This penalty is also provided for anyone knowingly infecting any person with venereal disease.

"Anyone making statements to the effect that a person has one or other of these diseases except in case of disclosures made in good faith to a medical officer of health or physician in consultation is liable to a penalty of $200.

"Provision is made with the object of maintaining secrecy in respect to cases of this nature by those who have the administration of the Act.

"The most important feature of the bill lies, however, in the powers given the Provincial Board to make regulations in regard to the *forms* and *notices* to be used in the administration of the Act, the *remedies* to be used, the *course of conduct* of the patient, the *distribution of information* concerning these diseases, the *regulation of treatment* in hospitals, etc., *preventing* infection, *reporting of cases* by serial number, *notices* and *placards* in public places, *imposing penalties* for infringement of regulations, *procedure* in appeals which may be made as a finality to the board and the *method and extent of examination* of persons.

"The board is given power to manufacture and distribute remedies free or otherwise to local boards of health, physicians and hospitals.

"Any expense in carrying out the provisions of the act may be incurred by the medical officer of health or local board, and such expense must be met by the municipality. The regulations under the Act are now in course of preparation and the law goes into effect July 1, 1918.

"While the effect of this law, which is a fairly drastic one, can scarcely be foreseen, it is reasonable to regard it as a decided step in advance.

The restriction of practice in these diseases to qualified physicians and the prohibition of the advertising of quack remedies will, it is hoped, do much to eliminate the baneful effects of treatment by druggists and quacks, who not only do no good, but usually do a lasting injury to the victims of these diseases, not only by leaving them uncured, but in addition, by giving them a false sense of security, which allows of the transmission of disease to innocent parties. Reporting of the names of those infected, which does not seem to have worked well in practice elsewhere is not sanctioned by the Act, but reporting by number is required."—John W. S. McCullough, M. D., D. P. H., Chief Officer of Health, in the *Public Health Journal*, Toronto, May, 1918.

The Non-Restraint System in the Insane Wards of Nagasaki Hospital, Japan

An article by Dr. Noboru Ishida, Professor of Psychiatry, Nagasaki Medical College, and Chief Alienist of the Prefectural Nagasaki Hospital, Nagasaki, Japan, which appeared in the June number of *The Modern Hospital*, gives an acount of the care of the insane in the special wards for their treatment in this general hospital. Dr. Ishida emphasizes their system of non-restraint and its benefits. The article is well illustrated.

In 1913 a small building containing 20 beds for mental cases was constructed at this hospital. This building has no guarded windows and no locked doors. A patient upon admission must have a bath for purposes of cleanliness before he is conducted to his room, and if necessary he is given a continuous bath. There are five rooms for patients, three of which contain six beds each. Each patient has an attendant, and the patients are not left to themselves. In addition to the rooms for the patients, there are a dispensary, a laboratory, a small green-house, and rooms for physicians and nurses.

Dr. Ishida states that there has been no suicide in the building since its opening, and that the number of suicidal attempts has gradually diminished. In the first year fifteen patients attempted suicide, four in the second year, and three in the third year, although in both the second and third years there were twice as many patients as in the first year.

The following extract from the July number of *The Modern Hospital* in regard to Dr. Ishida may be of interest:

"Dr. Noboru Ishida, author of the article on "The Non-Restraint System in the Insane Wards of Nagasaki Hospital," published last month, was elected an honorary member of the American Medico-Psychological Association at its recent meeting in Chicago. Dr. Ishida intends to establish communication between the American Medico-Psychological Association and the similar society existing in Japan. Readers of Dr. Ishida's article in *The Modern Hospital* will be interested

to know that Dr. Ishida is the author of the most popular text-book on psychiatry used in Japan, which has gone through seven editions and is about to be issued in an eighth edition. Dr. Ishida says that his advanced ideas in regard to non-restraint of insane patients were at first much opposed by government officials, whose respect for precedent caused them to throw many obstacles in his way. He now finds no difficulty in extending the application of the non-restraint principle. The two features of American psychiatric hospitals which particularly impress themselves on Dr. Ishida are their great size and complete equipment and the sympathetic understanding of the insane shown in their treatment."

War and the Woman's College

Professor Grace A. Hubbard, in the *New Republic* for July 6, reviews the kinds of war work undertaken by the various colleges for women: The Smith Reconstruction Unit, the Vassar Training School for Nurses, the Bryn-Mawr Service Corps, the Barnard Agricultural Unit, the Mt. Holyoke summer course to prepare leaders to look after the health of women in industry, the Bryn Mawr summer course to train leaders for industrial plans. Concerning the summer course at Smith for the preparedness of psychiatric social workers, Professor Hubbard writes:

"Smith College, while not a pioneer in the work it is to initiate this summer, is about to launch an experiment that is perhaps more of a hazard than any of these others because the field in which it is to work is itself in its infancy. Smith is to have a training school in psychiatric social work. It is to be conducted in conjunction with the Boston Psychopathic Hospital under a subcommittee of the National Committee for Mental Hygiene. This subcommittee is made up of four well known psychiatrists and the president of Smith College. There will be two months of lecture work at the college combined with clinical work in the hospitals of the neighborhood, and followed by six months of practical work in different hospitals that maintain a psychiatric department. Students may select hospitals near their homes if they wish. Three principal courses are offered; one in applied psychology, one in sociology and one in social case methods. This school is for graduates, but also for others that have had technical experience.

"'We shall be in great need of social workers who have been trained in psychiatric work,' states one of the committee. 'The work of the psychiatrist, the medical man, is not sufficient. We need a corps which will act as a sort of clearing house for all the problems confronting the shell-shocked man. We need people who have specialized not only in the usual field of social work but who have made an intensive study in psychiatry.' This specialist adds that if he can make use of a sufficient number of aids of this sort so that he may be freed to give himself to the part that he alone can do, he can treat some three hundred cases a day.

"'What in the world is psychiatry?' many asked when the plan was first proposed. Used in this connection it covers all forms of mental disorder, from the light nervous shock to insanity in a serious form. The term 'shell shock' has come to be a sort of blanket term covering all kinds of mental and nervous disorders.

"Here then is another field for women who want to help in the rehabilitation of disabled soldiers, not only in the hospital, but later, when all sorts of work will be needed in order to get men back into the social system in some normal line. It is a field suggestive of the trained nurse's, yet quite different.

"This is the immediate object of Smith's plan. But an added interest lies in the fact that almost all modern methods of dealing with civic problems, from the training of little children in the home and school, to the most complicated of provisions for the well being of citizens in all lines, are based on this type of training, or should be. The need for trained social workers will be even greater after the war, and no social problem can be adequately worked out without some knowledge of applied psychology."

Military Neuro-Psychiatry

Major Menas Gregory has been appointed Director of Psychiatry at the Port of Debarkation, New York. Soldiers returning from the Expeditionary Force suffering from nervous or mental disease will be examined by Major Gregory and his assistants and transported to the special hospitals provided for their treatment. Major Earl D. Bond is in charge of the psychiatric work at the Port of Debarkation, Newport News.

Major Richard H. Hutchings, Superintendent of the St. Lawrence State Hospital, Ogdensburg, New York, has been relieved from duty in the Office of the Surgeon General, Washington, to become Clinical Director of the Hospital for War Neuroses, Plattsburgh, New York.

Dr. E. E. Southard, Director of the Boston Psychopathic Hospital, has been appointed Vice Chairman of the Committee on Psychiatry of the National Research Council. Major Stewart Paton, Chairman of the Committee, is on duty at Camp Mills, Long Island, as a member of the Medical Research Board of the Aviation Section. This board is composed of eminent specialists who are engaged in studying the medical problems incident to aviation.

Captain Amos T. Baker, Psychiatrist to the Westchester (New York) County Penitentiary, formerly Director of the Psychopathic Clinic, New York City Police Headquarters, is on duty at the U. S. Disciplinary Barracks, Fort Jay, New York.

Major Edgar Fell of the Illinois State Hospital Service, formerly of the Boston Psychopathic Hospital, has been appointed Clinical Director of

the psychiatric service, Base Hospital, Fort Sam Houston, Texas, Headquarters of the Southern Department.

Captain Oscar C. Wilhite, Superintendent of the Lake Geneva (Wisconsin) Sanitarium, formerly of the Kankakee (Illinois) State Hospital, has been appointed Clinical Director of the psychiatric section, U. S. Army General Hospital No. 6, Fort McPherson, Georgia.

Major Herman M. Adler, State Criminologist of Illinois, formerly Chief of Staff of the Boston Psychopathic Hospital, is on duty at the U. S. Army Disciplinary Barracks, Fort Leavenworth, Kansas, studying the disciplinary methods of the army.

Captain Ransom A. Greene, Assistant Superintendent, Monson (Massachusetts) State Hospital, has been ordered to Camp Devens as camp psychiatrist.

Captain William O. Krohn of Chicago has been ordered to Camp Travis, Texas, as camp psychiatrist.

Major George E. McPherson, Assistant Superintendent, Medfield (Massachusetts) State Hospital, is camp psychiatrist, Camp Upton, Long Island.

Captain Nathaniel H. Brush, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, is in charge of the neuro-psychiatric examinations, Medical Officers' Training Camp, Fort Oglethorpe, Georgia.

Captain T. J. Orbison, Chief of Neurological Service, Los Angeles County Hospital, formerly of the Pennsylvania state hospital service, is Clinical Director of the neuro-psychiatric service, Letterman General Hospital, San Francisco.

Major Eugene D. Bondurant, Dean of the Medical Department, University of Alabama, formerly Superintendent of the Alabama State Hospitals, is in charge of the neuro-psychiatric service, Walter Reed General Hospital, Washington, D. C.

The neuro-psychiatric service, U. S. Army General Hospital No. 2, is in charge of Major Arthur P. Herring, Secretary of the Maryland Lunacy Commission.

The Hospital for War Neuroses, Plattsburgh, New York, is under the command of Lieutenant Colonel T. D. Woodson, of the Regular Army Medical Corps.

Neuro-Psychiatrists Serving as Contract Surgeons

A number of well known neurologists and psychiatrists have accepted contracts for the summer and are assisting in the neuro-psychiatric work at the following camps and hospitals:

Dr. Carl D. Camp, Ann Arbor, Michigan, Camp Meade, Maryland; Dr. W. T. Kradwell, Wauwatosa, Wisconsin, Camp Dodge, Iowa; Dr.

Allen R. Dieffendorf, New Haven, Connecticut, Camp Devens, Massachusetts; Dr. A. B. Ames, Waterville, Maine, Camp Devens, Massachusetts; Dr. Arthur A. Sweeney, St. Paul, Minnesota, Camp Dodge, Iowa; Dr. Charles L. Allen, Los Angeles, California, Camp Lewis, American Lake, Washington; Dr. Leo M. Crafts, Minneapolis, Minnesota, Camp Funston, Kansas; Dr. Peter Bassoe, Dr. George W. Hall, Dr. Hugh T. Patrick, Chicago, Illinois, Fort Benjamin, Indiana and Camp Zachary Taylor, Kentucky; Dr. Swepson J. Brooks, New York City, Camp Upton, Long Island; Dr. M. A. Bliss, St. Louis, Missouri, Fort Oglethorpe, Georgia and Fort Thomas, Kentucky; Dr. C. Macfie Campbell, Baltimore, Maryland, General Hospital No. 9, Lakewood, New Jersey; Dr. Albert M. Barrett, Ann Arbor, Michigan, Dr. Smith Ely Jelliffe, New York, Dr. Walter Timme, New York, Dr. Leonard Blumgart, New York, Hospital for War Neuroses, Plattsburg Barracks, New York; Dr. James J. Putnam, Boston, Massachusetts, General Hospital No. 1, Williamsbridge, New York, and Plattsburg Barracks, New York; Dr. Robert L. Richards, Talmage, California, Vancouver Barracks and German Prison Camp, Fort Douglas, Utah; Dr. Bruce Allison, Dr. Wilmer Allison, Fort Worth, Texas, and Camp Bowie, Texas.

Development Battalions

By order of the Secretary of War, Development Battalions are being organized at each National Army, National Guard, Regular Army Divisional Camps and such other camps as the Secretary of War directs. The functions of the Development Battalions are:

a. To relieve divisions, replacement organizations, etc., of all unfit men.

b. To conduct intensive training with a view to developing unfit men for duty with combatant or noncombatant forces either within the United States or for service abroad.

c. To rid the service promptly of all men who, after thorough trial and examination, are found physically, mentally or morally incapable of performing the duties of a soldier.

Prevention of Shell Shock

Bulletin No. 4 of the War Department announcing to the Army that the Surgeon General has made special provision for the care and treatment of soldiers suffering from nervous and mental disease, states:

"The foregoing facts are announced for the special benefit of persons that are brought socially in contact with soldiers, as such persons are in a particularly favorable position to witness the early stages of mental disease, and by their prompt and co-operative action may render valuable assistance in preventing nervous breakdowns. Reports from abroad indicate that a large number of the soldiers who break down nervously (shell shock) had, for several days before their final collapse, given evi-

dence that they were fast approaching the limit of their nervous endurance. It is believed that had something been done for them during those critical days they would have readjusted themselves quickly and gone back to their duty instead of remaining nervous invalids, with little prospect of recovery before the end of the war. Nervous breakdowns often begin by sleeplessness, persistent homesickness, nervousness, depression, self-reproach, unreasonable fear, suspicion of others, feeling of resentment against others, and general complaints of ill health. These signs often show in the man's social conduct, so that he is remarked by his companions as being restless, jerky, inclined to stay by himself, bad tempered, etc.; in other words, his companions remark that some change has come over him. The man himself may realize that he is out of sorts, but often he does not realize that he is ill, and so does not report at sick call; on the contrary, he often resents the idea that he needs the care and supervision of a physician. Yet a little rest, care, and medicine, such as would be provided if his case were brought to the attention of a medical officer, would in all probability suffice at this time to put the man on his feet again."

"In Line of Duty"

A case to be discharged "in line of duty" and therefore with certain claims upon the government, is defined in the following order issued by the Adjutant-General (G. O. 47):

"Hereafter any soldier who shall have been accepted on his first physical examination after arrival at a military station as fit for service shall be considered to have contracted any subsequently determined physical disability in the line of duty, unless such disability can be shown to be the result of his own carelessness, misconduct, or vicious habits, or unless the history of the case shows unmistakably that the disability existed prior to entrance into the service. The same rulings shall apply in the cases of officers who have been passed as fit for service on physical examination upon entrance into the service."

Feebleminded and the War

A well-known American psychiatrist now on duty in France writes as follows: "And just one recommendation. Keep the feebleminded home. I know there is a difference of opinion as to whether or not there is any place for them in the Army. Maybe there is, but not *here*. They drop their Mills' bombs and run, they get cold feet and endanger the military reputation of the finest body of fighting men in the world, who are 'carrying on' before the most critical eyes. They get into disciplinary troubles and are dealt with, in nine cases out of ten, without reference to their feeble minds. If they are *not* children, all we have been saying about childish minds in adult bodies is sentimental rot. If they *are* children, the hell of the trenches is no place for a child. If

anyone thinks that the officers of labor battalions have time or inclination to make special allowances for the feebleminded members of such organizations, he has not seen those organizations at work in France. If providing cannon fodder for the Boche's guns will help win the war, send them over. It won't; what will win the war is an Army of keen, alert, steel-nerved, clear-eyed American soldier boys who will outfight the Hun every time they meet him hand to hand."

The Trouble Buster, published at Fort McHenry, U. S. Army General Hospital No. 2, by the class in printing, gives an account in its issue of June 22, of the opening of the psychiatric ward at the hospital, when a joint meeting of the medical staff of the hospital and the Baltimore County Medical Society took place at this post.

". . . . At five the company assembled to inspect the new ward, which they found most attractive. The ward is for the treatment of mental cases in their early stages. Usually this treatment consists chiefly of mental hygiene, that is, of keeping the patient in an atmosphere of rest and quiet, though not one of indolence. He is given light work and recreation in due measure, so that his mind may be occupied with thoughts other than that of its own disorder. Some few patients will do their work in the court behind the ward; those who are not seriously ill will so far as possible work with the other patients in school and shop. Already Major Herring has succeeded in obtaining a fine spirit of cooperation from the patients in the ward, and all do their best to help along the others. This spirit of helpfulness bodes well for the increasing success of the work."

A Section of Anthropology in the Division of Medical Records in the Office of the Surgeon General has been created. Major Charles B. Davenport, Sanitary Corps, N. A., formerly Director of the Eugenics Record Office, Cold Spring Harbor, New York, is designated as the Officer in Charge. The functions of this section are to be: To secure the highest quality of the measurement of recruits and of identification records as done by the Surgeon General's Office for the Purposes of the War Department; to assist, as called upon, in the analysis and synthesis of the statistics compiled from medical records; to care for and help analyze physical examination records; to care for and classify identification records; and to assist the War Department in all questions about racial dimensions and differences.

Treatment of War Neuroses at the Seale-Hayne Military Hospital

The following account of the methods employed in the treatment of war neuroses at the Seale-Hayne Military Hospital, Newton Abbot, Devon, England, was recently received in a letter from Major A. F. Hurst, R. A. M. C., Officer in Charge of this hospital. Major Hurst was formerly in charge of the Neurological Section of the Royal Victoria

Hospital at Netley. This section has recently been given up, and the Seale-Hayne Military Hospital, with 225 acres of land, has been opened as a special institute for 300 or more men suffering from war neuroses.

The war neuroses can be classified into three main groups, which require different initial treatment, the treatment in the later stages being identical.

First Stage of Treatment

(1) *Hysterical symptoms.* Paraplegia, monoplegia, mutism, aphonia, stammering, tremor, contractures and disorders of hearing and vision are the most common hysterical manifestations. In the vast majority of cases they can be cured in a single sitting by pure persuasion and re-education. This can often be accomplished in a few minutes, but sometimes three or four hours of continuous treatment are required. Electricity is only used occasionally, when it is necessary to demonstrate to a patient that an hysterically paralyzed muscle is really capable of contracting. Hypnotism is now never used for these cases. The initial treatment must often be followed by systematic re-education by an instructor for a few days, especially in cases of long standing. With this exception the patients are put at once on the second stage of treatment which is described later.

(2) *Neurasthenia.* Only in severe cases of pure neurasthenia is any preliminary treatment required. This consists of rest in bed with complete muscular relaxation for a few days. The majority of cases are ready the day after admission for the second stage of treatment.

(3) *Psychasthenia, including nightmares, phobias and obsessions, and amnesia.* These conditions require "therapeutical conversation," in which the medical officer attempts to gain the patient's confidence and discusses intimately all his worries. In some cases hypnotism is required, but this is rarely practiced on more than three or four consecutive evenings and often only once. These patients are treated in isolation rooms by themselves, and are at first kept in bed. Frequently they are fit in a few days to do isolated work on allotments before entering upon the second stage of treatment.

Second Stage of Treatment

This is the same for hysterical patients, who have recovered from their symptoms, but require to be kept under observation for at least six weeks to prevent the possibility of recurrence, for neurasthenics, who require about the same length of treatment in order to recover completely, and for psychasthenics, who often require three months or more, and often then are only fit to be discharged from the service although this is never done until they are physically and mentally fit to earn a good living in civil life, requiring a pension of not more than 20 or 30 per cent. The patient is asked what was his occupation in civil life and in the case of skilled dairymen, horsemen, poultry-keepers, gardeners, engineers,

plumbers, fitters, carpenters, etc., an attempt is made to let him follow his old occupation. Otherwise he is given ordinary farm work. The work is at first light and only lasts for a few hours in the morning and afternoon, but its severity and duration are steadily increased as improvement occurs. All non-specialist farmers have two days a week on hospital fatigues, the hospital work being run as much as possible by the patients themselves. They act as clerks, mess and nursing orderlies and are helping the engineers with the alterations and additions required to get the hospital ready for 300 or more patients. All of these men do half an hour's physical drill every day under an expert instructor. There is no work after 5 p. m. or on Saturday afternoon. At these times the patients are encouraged to box and to play tennis, croquet, bowls, skittles, golf, cricket and other games. The patients themselves organize and give a concert every Thursday evening and they have a cinema show every Sunday evening. An attempt is made to get rid of the hospital atmosphere so that the men come to regard themselves as farmers rather than patients. Already the results are much better than they were at Netley, where the facilities for carrying out this treatment in detail were much smaller. I hope to be able to send at least 75 per cent of the men back to full duty without a preliminary stay at a command depot after a period varying between six weeks and two months. The number should be further increased when the new army order is issued, which guarantees that any man recommended for six months' home service should not under any circumstances be sent abroad within this period. The remaining patients will be discharged from the service after between three and six months, but, as was the case at Netley, no man will be discharged until he is fit to earn a living and until he has made definite arrangements about the employment he will follow. It is always recommended that a pension not larger than 30 per cent should be given.

The Nature of Nervousness in Soldiers

Major Foster Kennedy, of the Royal Army Medical Corps (Harvard Unit), Neurologist to the Bellevue and New York Hospitals, writing upon this subject in the *Journal of the American Medical Association* for July 6, 1918, says;

"A conscious assumption of symptoms by soldiers in my experience—and in this I am completely supported by all other medical officers—is exceedingly rare; it is not rare for a man to go sick for a few hours to obtain a temporary alleviation of his lot, but very seldom does one meet a man malingering with a view to discharge from the service.

"The conditions under which the present war is being fought are the rudest and largest experiment in biologic adaptation to which the human race has been exposed. Before 1914, it seemed to most of us that civilization with its drains, and its banks, its social amenities by which to

prevent friction of the emotions, and its policemen and law courts to stop even the suggestion of physical clash, had stifled in us any possibility of living in an environment of danger and destruction, of dirt and foul odors. In the vast majority, the power of the human animal to exist in quite novel and abominable surroundings has been amply vindicated; but in a certain number the adaptation has been less complete, and be it noticed these people have been most often those who found even the normal life of peace time a hard and tempestuous affair. . . .

"The emotions of fear and pain constitute together our machinery of self preservation; in most of us swathed in the cotton bandages of our civilized lives but little call is made on them. Constant exposure to imminent destruction in war produces, however, a tautness of the nervous system, a strain due to powerful excitement and, I would submit, to the organic stress induced by the mobilization of biologic instincts heretofore dormant. These instincts of self-preservation do not always, and perhaps not often, become conscious realizations. I mean that men, though in great danger, quite honestly may not feel afraid; their nervous systems may be said to be frightened, but their awareness knows no fear.

"This submersion of such a powerful emotive force below the threshold of consciousness is due partly, perhaps, to the person's knowledge of the debilitating effects on his energies of the entrance of fear into his conscious life, but much more, one feels sure, to the inhibitory influence of his morale. Now what is this thing we call morale? Is it not the expression in each soldier of his herd instinct, of his willingness to sacrifice himself for the benefit of his kind, and for the ideas held in common by his countrymen and himself? It is a loyalty to his mates, to his officers, to his regiment, to his nation, and, in the last instance, to the ideals of life for which his nation stands, and it is measured by his conscious willingness to suffer, his capacity for sacrifice in the common good. It is a quality born of the tribe, a product of gregariousness and so held socially in good repute. It is constantly expressed in thought; it is a real component of the soldier's conscious intellectual life. The shrinking from loss and the fear of death on the other hand are but rarely scrutinized in their realities; they are anti-social in trend and so are cast down, by good citizens into the limbo of subconsciousness. . . .

"For some months past I have been trying to discover something of the dynamic influences in our men, and I feel that a clue to the genesis of the neuroses is to be found in the antagonism on the one hand of the conscious emotions of loyalty and morale with their concomitant urge to self-sacrifice, and, on the other hand, the more or less satisfactorily repressed instincts for the conservation of individual life.

"The British soldier is not given overmuch to self analysis and investigation of his emotional processes; but questionings carried out as tactfully as possible have elicited in innumerable instances the information that being wounded, subsequent to or during heavy shell fire, is followed

by a period of mental rest. And it would be strange were it otherwise. Such a man experiences a sense of an honorable relaxation of effort; he is, for the moment, quit of his obligation to others, and freed from his fear of death. Further, his fate for the moment is decided, and despite his pain, he feels himself more fortunate than many of his fellows whom many times he has seen horribly destroyed. He waits for the stretcher bearers to take him, and in most men there is a conscious hope of a time of rest and home-coming.

"In such experiences, there are satisfied at once the man's biological instinct for self-preservation and his social instinct of loyalty to his comrades and to that ideal of conduct which has been his buttress in times of agony and stress.

"The converse situation in which a soldier suffers the stupefaction and profound bewilderment consequent on exposure to heavy shell bursts without being wounded, is one in which the obligation to persevere still remains with him, together with a prospect of indefinite repetitions of like abominations, culminating, as after a time becomes certain, in horrible mutilation or death. Under such circumstances, the conscious morale and idealism of the man—qualities, as has been suggested, of later growth than other instinctive processes—become drowned with the rising tide of his desire for life. The longing for safety, usually overborne by his conscious will, becomes overwhelmingly insistent, and is expressed by the entire organism being given over to the phenomena of fear. The individual becomes in mind and body, an automaton impelled by one instinct and one emotion; the mind, dazed and numbed, ceases to record impressions and is later found to be for that period amnesic. 'Dumb and palsied by fright' are only popular expressions of the loss of special senses and the generalized tremors which ensue. The defensive reflexes, the dodging movements of the head, the sheltering movements of the arms and the crouching movements of the body maintained for hours and days, and, under improper influences, for weeks after the lapse of the exciting physical cause, are an indication of the continued emotional tyranny under which he labors.

"In different individuals this conquering of the nobler altruistic part of the man by the lower and more selfish instincts takes place in different ways. It may and most often does occur as the result of profound fright, as has just been described; or, after a long period of mental conflict and strain, there may come a situation carrying with it complexes of such emotional strength as to render almost helpless the will power to endure. Such a case was that of an officer of my acquaintance who, having borne the racking experiences of the landing and trench fighting at Gallipoli, one day, jumping to what he took for solid ground, found himself—as he put it with a gesture of infinite disgust—squelching thigh-deep in decomposed Turkish dead. For weeks this experience recurred to his consciousness both by night in dreams and by day in dreaded

interruptions to his normal train of thought, rendering him for that period incapable of duty, a prey to the paralyzing influences of both repulsion and fear."

Major Kennedy points out the effect of suggestion by physicians in determining symptoms, and records a case interesting in respect both to the production of the symptoms and its cure:

"A motor truck driver, an Australian of fine character and physique, in the autumn of 1917 was worn out by constant night work in the front areas during which time his feet were almost always numbed with cold. He contracted so-called trench fever and was sent to the base. When in bed, he found that he had developed an acute dorsiflexion of the right foot and toes; this condition persisted through sleep and constituted a deformity of quite alarming appearance. Consultations were held in the case, and various opinions as to the character of the condition were expressed in the man's hearing. No conclusion was reached, and for some months electricity and massage were empirically given without modifying the position of the foot.

"An attitude of complete confidence on the part of the medical officer in his diagnosis and in his ability to cure the condition, followed by strong faradism to the calf muscles and to the sole of the foot, and then by rapid re-education in walking later abolished the spasm in two sittings. The purely mental nature of the ailment was explained to the patient; he was told how, when one wished to move, for instance, one's arm, it was necessary, first of all, to will to move the arm, how that act of will caused energy to come from certain brain cells, which energy went down through certain nerves to the arm, which then was put in motion. He saw quickly enough how an injury in either the battery, i. e., the brain, or the wire, i. e., the nerve tracts, could prevent movement taking place; whence, he came himself to the conclusion that in order to initiate the progress, it was also necessary to throw in the switch, i. e., the will to move.

"He was shown that by his defect of will power he had become for a time no longer master in his own house. It was made very clear to him, without, of course, crude words, that the medical officer knew he was not malingering, but appreciated and sympathized with his condition of fatigue which antedated the outset of the spasm. On the other hand, reference was made to the prolonged period of rest which had been his; our need of fit and capable men like himself was touched on, and there was brought to his mind the price daily being paid by our comrades for our security. In this way, his morale was stimulated and, with gratitude for his recovery, he applied for an immediate return to the line."

The term "shell shock," Major Kennedy holds to be inapt, and suggests the use of the term "nervousness":

"The essential feature of these ailments having been grasped, they must be classified and christened. In the beginning of this paper it was

pointed out how the term 'shell shock,' founded on false premises, not only served to suggest an incorrect etiology, but also, by its pitiful and romantic sound, tended to perpetuate symptoms and to excite no determination in the mind of the sufferer to recover his control, or, in the fighting man, still to endure. So far is it from making an appeal to conscience or to discipline that it stifles both, and stultifies effort toward cure.

"The name is a mistake; we must be rid of it. Let us have instead a true term which will be neither a compromise nor a technicality, unintelligible to the mind of the soldier.

"Hysteria is unsuitable in that its significance to laymen and physicians is not identical; nor does it embrace, for instance, such conditions as the anxiety neuroses. The simple word 'nervousness' comprises all the neurotic manifestations seen in war. It furnishes an appeal to the sense of discipline in the armies, and further promotes the growth of public opinion, both military and civil, which would be of the greatest prophylactic and therapeutic power.

"This diagnosis would continue to be divided into nervousness (sick) and nervousness (wounded), as now obtains, according to the external conditions to which the man was exposed at the time of breakdown. This change in military nomenclature would make clear to both soldiers and civilians that such diagnoses need not necessarily be followed by a return to home or to the base, and would clearly indicate the propriety of dealing with such cases diagnostically and therapeutically in rest camps, and especially work camps, in front areas and on the lines of communication."

CAPTAIN SMITH—77

". . . . The inefficiency which springs from undue political influence has received from him [Secretary Baker] the greatest check in our military history; and this point in his policy is again illustrated, and illustrated magnificently, by General March's recent order requiring every American officer up to the grade of brigadier-general, to carry a terrible scientific card on which, from the hands of his purely military superiors, he receives a purely military and non-political technical 'rating.'

"This 'rating' system is one of the novelties and curiosities of the war. We have never before had anything like it, in method. It was devised by Walter Dill Scott, formerly a professor in psychology at Northwestern University and now Director of the War Department's Committee on the Classification of Personnel. Dr. Scott's proficiency in psychology might lead one to fear that he would 'rate' our officers by means of ergographs and electric currents and nerve-reactions and lists of memorized numerals and other psychological laboratory-tests. But he is guiltless. His 'rating' system now being applied to all our

officers throughout all our camps, is based absolutely on 'practical' comparisons between man and man and not all on 'theoretical' deductions from laboratory-tests or, for that matter, from examination-papers. Laboratory-tests and examination-papers will weed out the feebleminded and will perform various other services. But our 'rating' system for the promotion of our sound-minded and sound-bodied officers to higher grades is a genuinely man-among-men system.

"Besides which, it is a fascinating game. Imagine yourself a Major. It is your duty to 'rate' all the Captains who are your subordinates. You proceed as follows:

"First, you make a 'rating-scale.' You make a 'rating-scale' for each of the five considerations on which you are going to 'rate' your subordinates. These considerations are: Physical Qualities, Intelligence, Leadership, Personal Qualities, and General Value to the Service. The greatest number of 'points' which you can give to any subordinate for General Value to the Service is 40. The greatest number you can give him for any one of the other four considerations is 15. The greatest possible total of 'points,' therefore, for the perfect officer is 100.

"You begin, we will say, with Leadership. You are about to make a 'rating-scale' for Leadership. You think of the officers you know of your own rank. You think of Majors. These Captains will be, or will not be, promoted to Majors. Among the Majors in your acquaintance, which one would you pick out as ranking highest, in your estimation, for Leadership, for 'ability to command the obedience and the co-operation of other men'? You mark him down at the top of your Leadership 'scale.' He is the maximum. He is 15.

"Now among all the Majors you know, which one is worst for Leadership? And which one is 'just about average'? You mark down the average Major, in the middle of your scale, at 9. You mark down the worst Major at the bottom, at 3. You now have a scale for Leadership, and it is made not of theories but of Majors. It is made of flesh and blood.

"Whereupon, equipped with this scale, you proceed to rate Captain Smith. You find that for Leadership, in your estimation, he is far above Major Black, at the bottom, and quite a bit above Major Gray in the middle, but clearly not altogether the man that Major White is at the top. Yet he approaches Major White, who is 15. You give him we will say, 14.

"For intelligence, having made an Intelligence scale, consisting again of Majors, you give Captain Smith perhaps only 8. Captain Smith is not brilliant. He has no conspicuous 'ease in learning.' And on Physical Qualities you can give him only 8. But on Personal Qualities, such as 'industry' and 'loyalty' and 'readiness to shoulder responsibility for his own acts,' he compares favorably with any Major you have ever met.

You would like to give him 16. But there is no 16. You give him 15. And on General Value to the Service, taking him all in all, especially on the question 'whether or not he can arrive quickly at a *sensible* decision in a crisis,' you decide, after comparing him with the Majors in your General Value scale, to give him 32, which is only eight short of the best.

"Captain Smith's total then is 77. It is a high total. The normal total is 60. That is, if a man gets the average rating, the middle rating, in each of the five rated considerations, his final totaled rating will be four 9's plus a 24—which is 60. Your average officer is 60. Captain Smith, with all his defects in verbal memory, and in chest-measurement, is well above the average. He might not shine at examinations. He might not shine at laboratory-tests. And he might make a less than an average impression, at first sight, on a new commander in a new camp. But here you have a rating-system which is not academic and which is not, nevertheless, merely impressionistic. It is a really human record, put into a scientific statement.

"Captain Smith carries his card with him to his next camp. And he carries it with him to France. General Pershing has particularly requested that every officer sent over shall bring his card with him. It goes in an envelope, sealed; and the officer delivers it, immediately on arrival, to his next superior. It does not determine his promotion. That is, it does not foreordain it. This system is not in any way a Chinese system. Captain Smith's rating, made by his Major and then revised by his Colonel, is not in itself conclusive to his superiors, but it is an element and it will be an increasing element, in their dealings with him.

"And it is beautifully conclusive to Senators and especially to Democratic Senators and to other most distinguished persons conscious of their political importance.

"Captain Smith's card, in duplicate, goes to Washington. It lies there in the War Department. So does Captain Jones's. Captain Jones is only 25 in his rating. The Adjutant General's office knows that he is only 25. And when a Senator or Congressman comes to intervene on Captain Jones's behalf and begins to describe him as the darling of his regiment and the hero of his regimental mess, the answer is ready and irresistible. Without this card, the War Department could only say that it preferred its own personal preference to the Senator's personal preference. With it, the War Department stands on figures. And yet, the figures, most happily, are personal preference, too—the personal preference of military persons, reached by a systematized comparison of military personalities in the field."—William Hard, in *The New Republic*, July 6, 1918.

The Mentally Deficient Recruit

Canada's experience with the mentally deficient recruit is thus described by Capt. O. C. J. Withrow, C. A. M. C., in the March number of the *Public Health Journal*, Toronto: "For there is no shadow of a doubt that mental defectives give great concern to a Medical Officer of a unit as soon as they have donned their uniforms. Every fellow may look alike in khaki, but every man doesn't act like his comrade any more than do the units in civilian life. Deficient mentality shows itself early or late. The greater the deficiency, the sooner the discovery. The sergeant reports that Pte. Bill Smith is too stupid to learn any drill. The cook house sends word that Pte. Tom Jones is no good around the pots and pans. The Sanitary Squad won't have the last man detailed to them; all he does is to stare at the landscape. The Medical Officer greets these recruits at his morning sick parade, and has very little difficulty in pronouncing a diagnosis—likewise a prognosis. The difficulty arises when an attempt is made to have such discharged from the army. This takes trouble and it costs money. These are the simple cases—what complexities are involved with the others!

". . . . Many loyal and devoted persons have expressed their convictions that it seems a great pity to send all the physically fit to fight our battles with the prospect of death or disfigurement, while those of lesser physical attainments are left at home. It seems a greater hardship that we leave behind the mentally defective while those of brighter intellect march off to do exploits. But what will you? War is war, and it takes the keenest and the bravest to stand the rigors of a campaign. And one deficient intelligence may cause a cataclysm of disaster in many an hour of expected triumph."

The first number of the *Revue Interalliée pour l'Etude des Questions Interessant les Mutilés de la Guerre* appeared in April. The subjects to be treated in this review are stated as the following: physiotherapy, prothesis, functional and professional re-education, and questions of economic and ethical import to disabled returned soldiers. The review is published bi-monthly, is edited by Dr. Jean Camus of Paris, and is the official organ of the *Comité Permanent Interallié pour l'Etude des Questions Interessant les Invalides de la Guerre*, of which Dr. Bourillon of France is President, and Charles Krug, also of France, General Secretary. The membership of this committee includes prominent citizens of Belgium, Great Britain and her possessions, the United States, France, Italy, Montenegro, Portugal, Roumania, Russia and Serbia. The members from the United States are J. Caffery, L. A. Cresset, H. Folks, Grace S. Harper, Dr. A. Lambert, Dr. H. W. Miller, A. F. Sanborn, Dr. Veditz and Major S. H. Wadhams.

The first part of the review contains original articles by Professor Agathonovitch, Vice-President from Serbia: Brieux, member from

France; Professor Broca; Golonbeff and Dronsart, the former member from Russia; Professor Galeazzi and A. Lollini, the former member from Italy; Grace S. Harper, member from the United States; Madame Simone Laborde; General Melis, Belgian Vice-President; Joseph Neujean; Major Ripert; Constant Verdot, and Colonel Stanton, member from Great Britain.

The second part consists of reprinted proceedings of meetings of the Standing Interallied Committee and of the first Interallied Conference, of laws and proposed laws in Belgium, France and Italy, a list of reconstruction schools and agencies, and of books, articles, journals and miscellaneous works on the subject of reconstruction work with disabled soldiers.

BOOK REVIEWS

STANDARD METHOD OF TESTING JUVENILE MENTALITY BY THE BINET-SIMON SCALE WITH THE ORIGINAL QUESTIONS, PICTURES, AND DRAWINGS. By Norbert J. Melville. Philadelphia: J. B. Lippincott Company, 1917. 142 p.

This excellent little manual is intended for the training and use of advanced students of applied psychology who wish to co-operate in the work of grading and classifying children and others of juvenile mentality on the basis of their mental development.

Part I of this manual includes directions for using the standard record form which has been adopted by the public schools of Philadelphia. The grouping of the tests by years is identical with that of Binet and Simon, series of 1911.

The tests are divided into two series:—those shown to be most highly diagnostic in differentiating the mentally deficient from the normal; and those next in diagnostic value.

By using the Binet quotient (which the author explains), the Binet-Simon age-grade method becomes transformed automatically into a point-scale method, if one wants to use it that way. As such, the author claims for it superiority to any other point scale that has been proposed, because it includes a larger number of tests, and its points have definite meaning.

Principles for guidance in the administration of the tests and the evaluation of the data are included in Part I, together with a selected bibliography representing some of the numerous fields of activity where the Binet-Simon scale has proved valuable.

Part II comprises the "Uniform Method" of applying the Binet-Simon scale with notes suggesting supplementary trial variations. The "Uniform Method" is not another revision or adaptation of the Binet-Simon tests. The standardization is based upon the author's experience growing out of an application of the recommendations of the Buffalo Conference on Binet Testing, together with a comparative study of the methods used by other investigators.

Certain practical correlations appear to the author to be worthy of attention: that the qualifications in the matter of training and experience for Consulting Psychologists and Field Examiners be more accurately defined; that the Binet age score be not accepted on its face value, recommending instead its interpretation in terms of mental growth periods in the light of group norms and of supplementary data; and that, finally, instead of attempting to make adaptations of the Binet scale, investigators should strike out along new lines in the development of supplementary scales.

Orthogenic and psycho-educational tables are given in the Appendix, to serve as guides in the work of provisional classification.

A table of anatomical limits is given, and a method of collecting supplementary data is offered.

One can agree with the author that the method lends itself well to a study of deterioration groups, dements, etc., and furnishes valuable data for differential diagnosis in this connection.

The Uniform Procedure developed by the author is based upon more attention to detail than any other manual of directions we have seen.

Every word of the "Summary of General Procedure," on page 41, is well worth most careful perusal.

The limitation of this tool in mental diagnosis is well recognized by the author. Any measuring scale is in part only a convention adopted for practical purposes, and should only be used in connection with a complete study of the case, including all obtainable data—medical, psychiatric, social and such. These points the author clearly sees.

The reviewer takes pleasure in recommending this most carefully evolved manual. It can be read profitably by all students of mental diagnosis.

V. V. ANDERSON.

SYPHILIS AND THE ARMY. By G. Thibierge, M.D. London: University of London Press, 1918. 201 p.

This volume is one of a series of Military Medical Manuals translated from the French and published under the general editorship of the Director General of England, Sir Arthur Keogh, and edited by C. F. Marshall.

The aim of the book, which is written for medical officers in the army, is to provide them with adequate information about the nature, treatment and social effects of syphilis so that they in turn may influence public authorities, civil and military, to put in force all possible measures for its cure and the prevention of the further spread of the disease.

The volume may be divided into three main parts, the first dealing with the general problem of syphilis in France today, its incidence, mode of transmission and social effects; the second division considers the signs, symptoms and treatment, while the third discusses prophylaxis. It is the first part of the volume, in which the general social problem of syphilis is discussed, that is of most interest. Unfortunately this is quite brief, comprising but thirty-three pages of text. The author maintains that there has been a great increase of syphilis in France, since the beginning of the war in the army, munition works and among the civil population. Statistics are inadequate to express just what this increase is. It is estimated that there are from 4,000 to 5,000 contagions per month amongst the French troops, which in three years of war would make 150,000 to 180,000 infections.

It is found that soldiers at the front most often contract syphilis in the interior when on leave or in the depots before returning to the front. This accounts for about 70 per cent of the infections. In the army zone the chief danger is from women who are not professional prostitutes, i.e., restaurant keepers, barmaids, laundresses, seamstresses, farm maids; while in the base zone and among men mobilized in munition works, venereal diseases are most often transmitted by the professionals. Among munition workers the incidence of syphilis is very high. Since men and women are thrown close together, immorality has been common; many prostitutes, finding their incomes diminished because of the absence of their clientele at war, have taken work in munition factories, plying their trade at the same time.

Syphilis has increased among the civil population as well as among the soldiers. Here it is the married women and young men who are the victims. The increase among married women is ascribed to the long absence of their husbands, diminished incomes and infection by their husbands who have acquired syphilis while in service. The young men are solicited by the prostitutes who, finding their usual customers absent, entice the boys not old enough to enter service.

The author summarizes the evil consequences of syphilis among soldiers as follows: "(1) It compels patients to submit to treatment which during the contagious periods cannot be carried out at the front, or while men are still engaged in munition works, because in a word it diminishes the effectives; (2) it diminishes a man's value; (3) being transmissible to a patient's descendants, it compromises the race at an epoch when, more than ever before, it is imperative that the race should be numerous and robust."

The bulk of the volume is now given over to a discussion of the symptoms, diagnosis and treatment of syphilis as observed in the army. The facts given do not differ in essentials from the known facts of symptoms, diagnosis and treatment in civil life, except that certain methods of treatment are preferred owing to the exigencies of military routine, such as the difficulty of procuring supplies and frequent reporting to physicians. The ideal of treatment that it "should be instituted in such a way that it will reduce to a minimum the ineffectiveness of the soldiers" is certainly one which should be current in the civil hospitals.

In the last portion of the book, the author deals with the prophylaxis of syphilis, once more emphasizing syphilis as a social danger. He takes up precautions for preventing the transmission of syphilis by infected men, such as isolation of carriers, adequate medical inspection and hospital treatment not only for soldiers at the front but for the munition workers, the creation of venereal centers in the army zone as well as in the interior, and post-hospital supervision; for noninfected men he advises personal talks with army physicians as well as lectures and dis-

tribution of pamphlets; for the civil population he favors the increase in the creation of centres for the treatment of syphilis, which has met with success in France, and supervision not only of known but of suspected prostitutes, a measure which has not been carried to the end in France.

The first thirty-three pages of the book give the information of chief value and interest. One wishes that more space had been allotted to this section rather than to the remainder of the book, which is in reality a manual of syphilis. As such it has a certain value, being brief, discussing the symptoms most likely to be found in soldiers and presenting the question of treatment from the standpoint of the exigencies of military service. However, one feels that it is elementary and incomplete. While of undoubted value to the busy military surgeon, it can hardly be considered as an addition to syphilology as a science.

The last division, dealing with the prophylaxis of syphilis, is sane and views the problem from a practical but wide angle. The suggestions merit study and consideration.

The book is written in a very clear and simple style. Directions for handling individual patients and army clinics are explicit and complete. To the military surgeon who is suddenly confronted with the necessity of treating syphilitics, it will be a most useful guide.

While calling attention in a forceful manner to the great dangers of syphilis, it is in no way sensational, and the facts and figures so carefully collected and compiled in the first section of the book are worthy of reprinting for purposes of propaganda.

HARRY C. SOLOMON.

NEUROSYPHILIS: MODERN SYSTEMATIC DIAGNOSIS AND TREATMENT. By E. E. Southard, M.D., Sc.D., and H. C. Solomon, M.D. Boston: W. M. Leonard, 1917. 496 p., illus.

In recent years the abundant literature relating to syphilis of the nervous system has shown a vast amount of study devoted to the subject. In presenting "Neurosyphilis," Southard and Solomon give a concrete analysis of their experience and study, and frankly point out the lessons to be derived therefrom. The first lesson is the unity-in-variety of the phenomena, by which is meant the spirotrichosis and its corollary the Wassermann reaction as the one constant in an almost endless variety of other phenomena. The second lesson is the value of a hopeful attitude toward therapy in all cases, even those of general paresis. The third lesson is the necessity of a complete serological study of every case of neurosis or psychosis. The book is stated to be written primarily for the practitioner and secondarily for those whose special work deals more constantly with syphilis in some form, for example, the psychiatrist and the neurologist. One feels that the majority of neurologists and psychiatrists will charge the writers with polite modesty, for except to workers in a few large clinics no opportunity is given for such clinical,

serological and pathological experience as forms the basis of this study. The material was furnished by over two thousand cases of syphilis of the nervous system in various stages and manifestations, supplemented by the study of over a hundred autopsies. Most of the patients came through the medium of the Boston Psychopathic Hospital, but those who are familiar with the close relationship which exists in fact, and not theory, with the Massachusetts public, due to the untiring personal efforts of Dr. Southard and the Massachusetts Commission on Mental Diseases, know that the problems presented by the patients studied differ in negligible degree from those seen in actual civil practice. The 137 cases which they cite confirm this. There is however a preponderance of the psychotic manifestations of neuro-syphilis, which is hardly a fault. Enough cases of syphilis of the spinal cord, root and peripheral nerve are presented to emphasize the lessons mentioned above, but not enough perhaps to cover the clinical display seen by the neurologist as distinguished from the psychiatrist. It is not the purpose of the book to include all those nosological entities. The work, therefore, can claim attention through the wealth of clinical and pathological material. But still further and more important claims rest on Southard's well-known interest and productive work in neuropathology and neuropsychiatry, and Solomon's recent intensive studies in the serology and treatment of neurosyphilis. Added to this is the close and efficient relationship of a splendid social service in the study of the entire subject. All of these things are well known of course to the friends of these Boston workers.

In the first chapter, entitled *The Nature and Forms of Syphilis of the Nervous System*, the writers quietly attack the problem of classification, and without urging its acceptance present one of their own to which they adhere pretty closely throughout the book. For the entire subject the term neurosyphilis is used, of which the main forms are: diffuse, vascular, paretic, tabetic, cummatous and juvenile. Any of these forms may be further qualified by indicating in appropriate terms the combinations of meningeal, vascular and parenchymatous involvement. Whether one is disposed to criticise this classification or not, there is a certain testimony of approval seen in the frequent use in the recent literature of the terms neurosyphilis, neurosyphilis tabetic type, etc. If there is any chance for further subdivision, it is in the group diffuse neurosyphilis, but thus far no one has succeeded.

As stated above, the book is made up of 137 case histories, each chosen to illustrate a given principle and presented with just enough detail to make it clear. Aside from the variations in the different cases the authors with true literary instinct hold one's attention by individualizing each person, so that he appears before one as a patient with a name (fictitious of course) and is so remembered. The first case, of Mrs. Alice Morton, is presented as a paradigm to show the possible abund-

ance and variety of symptoms and lesions in diffuse neurosyphilis. The clinical and histo-pathological findings are unusually rich and afford the authors a good opportunity not only to indicate the diffuseness of the syphilitic lesions but to correlate the clinical with the anatomical data. Furthermore, stress is laid on the fact that many of the symptoms are irritative, or at least due to lesions which are entirely recoverable. The other cases in this chapter include similar clinical and pathological studies of typical cases of tabes, paresis, juvenile paresis, vascular neurosyphilis, gummatous neurosyphilis and basilar meningitis. The reader is given an anatomical and pathological foundation, which is the only true way to approach the diagnosis and therapy of this protean disease.

The chapter on *Systematic Diagnosis* covers a wide range of cases both mental and neurological, with several striking examples of congenital syphilis. Some of the not unusual forms are omitted, such as the myelitides, cases of root pain, tri-geminal involvement, labyrinthine disturbance, etc. Especial attention is given to the diagnosis of paresis. Very striking is the statement that diffuse neurosyphilis may look precisely like paretic neurosyphilis at certain periods of clinical and laboratory examination. A similar statement appears in the preface: "We are confident that no one can now successfully make a differential diagnosis between the paretic and diffuse nonparetic forms of neurosyphilis in many phases of either disease." Attention also is drawn to the fact that remissions of identical appearance occur in paretic and in diffuse neuro-syphilis. The particular emphasis of this chapter is, however, put upon the serological tests, and a careful analysis is made of the variations found not only in the particular types but in the individual cases. The colloidal gold test has been given a prominent if not absolutely dependable place in diagnosis. In the authors' experience fluids from cases of general paresis in the vast majority of instances give a strong and fairly characteristic reaction, although very rarely the reaction will be weaker. While nonparetic cases in a fairly high percentage give the same reaction as paretics, still when the fluid does not give a strong paretic reaction it is presumptive evidence that the case is not general paresis. With this interpretation of the gold sol reaction, serological study has directed attention to an important group of cases, the so-called "paresis sine paresi" group, which calls for final interpretation in the light of further clinical study and subsequent history.

The chapter on *Puzzles and Errors* deals with a wealth of material illustrating many atypical forms of neurosyphilis, or what Collins sometime ago well described as "Unsuspected Syphilis in Neurology." Almost the whole gamut of psychotic disturbances is covered and many neurological syndromes, in all of which certain physical and serological signs compel the diagnosis of neurosyphilis. The difficulty of properly interpreting neurasthenia, hysteria, dissociated states sometimes seen in

undoubted syphilitics, is touched upon. The confusion which alcoholism, senility, brain tumor and pernicious anemia can cause is indicated. The whole chapter presents excellent points for differential diagnosis, in which the authors display a nice consideration of symptomatology, a ready reference to the literature and an easy familiarity with the serology and pathology of neurosyphilis.

Two short but timely chapters appear on neurosyphilis in its social, medicolegal aspects and on neurosyphilis in the war. No thoughtful person can fail to appreciate the bearing this disease has on the family, public, social and economic life of the individual. Our Government has already met its responsibility by discharging from the army every recruit showing signs of neurosyphilis. The case histories are interesting and suggestive, and the rules for the interpretation of the various problems involved quite clear. For the timid among us who fear causing unhappiness and breaking up of families by attempting to examine wives and children of syphilitics, there is much food for thought in the statement that "in doing this as routine for nearly three years and examining several hundred families there has been no instance to our knowledge in which the family has been broken or grave difficulties encountered."

The chapter on treatment is the best in the book. No better example of the author's general method of presentation of problem, attack and solution can be found. The whole subject of treatment is prefaced by the clinical history and autopsy records of five cases of neurosyphilis. Detailed analysis of the pathological conditions makes apparent what difficulties therapy must face, and proof is given that clinical study alone cannot anticipate the histological picture. The difference between inflammatory and degenerative lesions must be acknowledged. Meningitic processes can possibly be removed by treatment, but the degree of ultimate recovery depends upon the condition of the brain substance. Some cases show changes in infragranular layers and are unfavorable; some are associated with marked brain atrophy and are obviously hopeless for improvement. The degree of atrophy found at autopsy cannot at all be postulated by consideration of the duration or severity of the disease clinically. Further there are variations in the topographical distribution of lesions, and a case that may seem mild clinically may reveal at autopsy extensive involvement. On the other hand, the perivascular infiltration of lymphocytes and plasma cells does not warrant pessimism, for a somewhat similar condition, but without plasma cells, occurs in acute poliomyelitis. And still more encouraging is the fact that many of the symptoms are not due to parenchymatous degeneration but to various microphysical conditions of pressure and intoxication. One question awaiting solution is data regarding the precise habitat and toxic activity of the spirochæte. The prognosis therefore is not bad, even in paresis, for one may not by any means be sure it is paresis. In all fairness the prognosis should be made only after treatment has been tried.

The kind of treatment advised is intensive treatment with the salvarsan products as the main weapon. All methods are used, the precise one or combination depending on the individual case. It is admitted that the last word as to the best method has not been said, and no attempt is made to advocate any one. Many case records are cited, most of them considered paresis clinically, some of them diffuse neurosyphilis and tabetic neurosyphilis. Results were strikingly good, partial, or admitted failures. No charts are given showing percentages. While opposing therapeutic nihilism or optimism, a plea is made for hopefulness in approach toward each case, not only in view of actual results already obtained in some cases but because of the admitted chance of error.

In general, the chapter on therapy is the most temperate we have seen. It will be a comfort to many workers in this field who have been at least puzzled by various published reports showing percentage results of cure or improvement that seemed beyond them. By showing that the problem is individual in each case because of the variations in the pathology and the amenability to treatment, a considerable advance has been made in the therapy of neurosyphilis.

In reading the book there are several things that attract attention. The authors understand thoroughly the value of order, emphasis, repetition and summary. The blocking of essential statements in heavy type as a heading to each case history is very effective. The discussion of the unusual symptoms by questions and answers lends clearness and is seldom tiresome. The authors' style is charmingly direct and animated, and the book has a subtle entertaining power seldom seen in a purely medical treatise. Everywhere there is evidence of thoughtful consideration, from the appropriate frontispiece to the unique summary and key, not forgetting the quotations from Dante, which perhaps had best been reserved for a smaller audience of understanding friends. Finally, praise must be extended to the publisher for the clearness of the pathological sections, the best we have seen in any American book, and for the physical excellence of the book itself. Mention is made of these things because they are somewhat exceptional.

GEORGE J. WRIGHT.

NERVOUS CHILDREN; PREVENTION AND MANAGEMENT. By Beverley R. Tucker, M.D. Boston: Richard G. Badger, 1916. 147 p.

In this book the author does not profess to give a very systematic exposition of the nervous disorders of children; he discusses in a somewhat discursive way the problems which are associated with the nervous child. With regard to the familiar symptoms and disorders, the author gives us an enumeration and description rather than a discussion of the underlying causes and the special mechanisms involved. In the chapter on the cause and prevention of nervousness in children, mention is

made of the ductless glands in somewhat disproportionate detail; the advice as to prevention of nervousness is common sense. Special chapters are devoted to defective children and to some organic and functional nervous diseases. The book is written in a pleasant style and can be read rapidly.

C. Macfie Campbell.

Child Behavior; A Critical and Experimental Study of Young Children by the Method of Conditioned Reflexes. By Florence Mateer, Ph.D. Boston: Richard G. Badger, 1918. 239 p.

The author devotes the first three chapters to an interesting historical review before passing to the special methods of the Russian school, especially to those of Krasnogorski. Krasnogorski studied the formation of certain associations in young children, or, in other words, certain conditioned reflexes. In the ordinary or unconditioned reflex act the individual reacts to the stimulus in an adaptive way which is part of the instinctive pattern of the individual constitution. Thus a dog begins to salivate when meat is shown to him. It is possible to develop in individuals similar reflex reactions which are not part of the instinctive pattern of the animal's nature, but which are derived from the simple instinctive reactions through the experience of the individual. Thus a dog accustomed to hear a certain musical note before seeing meat will soon develop the reflex act of salivation in relation to this musical note even though the meat is not shown. It is obvious that facts of this nature are fundamental for any study of the process of learning, which essentially consists in the development of associations.

Krasnogorski utilized this method to see how quickly in children certain associations could be learned and unlearned. On the basis of his data he concluded that the method was of use for clinical purposes. He found that in neurotic children associations might be easily developed, but were dissolved with very great difficulty. This is an important observation in relation to the functional neuroses where we find that a single episode may leave such a profound trace that the later reactions of the individual are seriously modified by it. Krasnogorski observed that young children reacted to the sight of food with swallowing movements, salivation and mouth movements. He tested various children with regard to the length of training necessary to associate these movements with artificial stimuli such as cutaneous or sound stimuli.

In the present work the author gives us a concrete example of the application of this method. She has applied it to seven low-grade defectives, to a normal child studied intensively, and to a more or less unselected group of fifty children. The detailed conclusions of the author cannot be summarized, and the book is more interesting from the point

of view of method than from that of results. It is, however, a good example of a very promising new method of approaching the study of childhood in a sound and objective manner.

C. MACFIE CAMPBELL.

EDUCATIONAL PSYCHOLOGY. By Kate Gordon. New York: Henry Holt & Co., 1917. 294 p.

The influence of genetic and experimental psychology upon education is illustrated by this book. The concrete facts it contains are in striking contrast with the sorry platitudes that largely made up some of the older books on educational psychology. The author does not hesitate to begin with the growth and development of the human body, noting the conditions of physical growth, the distinction between chronological and physiological age, the importance to pedagogy of a knowledge of physiological and psychological development; and then she passes to the growth of behavior, instinct, the motor capacities of children, motor development, and the educational value of manual exercises, with hygienic and pedagogical suggestions.

Especially significant is the attention given to learning rather than teaching; the learning process as shown by observation, tests, and experiments; together with the economic methods of committing to memory, as suggested by the long series of experimental investigations from the pioneer work of Ebbinghaus to the studies of Meumann and Radosaljevitch, showing the advantages of the whole method for certain kinds of work, the importance of adapting one's method to one's individual type, the growth of memory with age, and the like. The author treats also of the mental processes of imagination, attention, feeling and will in relation to pedagogy, and briefly of the teaching of language, drawing and arithmetic.

A distinct merit of the book is the author's concrete statement of significant facts from the genetic point of view. This may be illustrated by the short chapter on the growth of reason which is in part as follows:

It is an easy matter to know a good memory, but it is often hard to recognize an act of reasoning. Reasoning is a new relating of terms. It depends on the ability to use symbols and concepts. It is sometimes identified with the classification and definition of experience. "It is an *ideal experiment;* it is synonymous with ingenuity in the *solution of problems.*" Children are concrete in their thinking. "Names mean to them the first tangible object with which they are associated. I know of a little Catholic child who thinks that the Holy Ghost is his left shoulder! In making the sign of the cross he, it seems, always touches his left shoulder at those words. When children learn to count they associate the number names with individual objects. Thus, if you count on the fingers for a child, calling the thumb 'one' and the little finger 'five,' he

will object if you start back the other way and call the little finger 'one,' because you just said it was 'five.' He takes all nouns as proper names at first. The child makes two kinds of errors; he attaches general names to particular objects, and, on the other hand, names which properly attach to special objects, like 'father,' he extends to any similar object and calls every man 'father.' The child starts with an experience which is neither general nor particular, and it is his task to work out the difference between the two."*

Meaningful associations are logical relations. The opposites test is probably the easiest of the logical relations tests. The list of easy opposites used by Woodworth and Wells ought to be answered by eight-year-old children with a score of about 95 per cent. Definition has been used by Binet and others as a test of intelligence. Up to the age of four he finds that a child cannot define. Definition by use is characteristic of children between the ages of four or five and nine. After nine the majority of children can give definitions that are better than by use. The young child classifies but does not define.

Since the principles of mental economy are not very remote from the principles of mental hygiene the book has its contribution to the latter subject as well as to educational psychology and gives a convenient résumé of many of the results of the significant psychological studies of recent years.

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BOOKS RECEIVED

Anderson, Meta L. Education of defectives. Yonkers: World Book Company, 1917.

Fernald, Walter E., Southard, E. E., Taft, Annie E. Waverley researches in the pathology of the feebleminded; research series, cases 1–10. (Memoirs of the American Academy of Arts and Sciences, Vol. XIV, No. II, May, 1918.)

Keogh, Sir Alfred, ed. Medical and surgical therapy: Vol. I, Infectious diseases; Vol. II, Neuroses; Vol. III, Wounds; Vol. IV, Fractures; Vol. V, Bones and joints. New York: D. Appleton and Company, 1918.

MacCurdy, John T. The psychology of war. London: William Heinemann, 1917.

Mateer, Florence. Child behavior: a critical and experimental study of young children by the method of conditional reflexes. Boston: Richard G. Badger, 1918.

Parmelee, Maurice. Criminology. New York: Macmillan Company, 1918.

* Pages 181–82.

Pintner, Rudolf. The mental survey. New York: D. Appleton and Company, 1918.

Ruger, Georgie J., comp. Psychological tests—a bibliography. Supplement to January 1, 1918. New York: Bureau of Educational Experiments, 1918.

Thibierge, G. Syphilis and the army. London: University of London Press, 1918.

Tucker, Beverley R. Nervous children. Boston: Richard G. Badger, 1916.

CURRENT BIBLIOGRAPHY*

April–July 1918

Compiled by

MABEL WEBSTER BROWN
Librarian, The National Committee for Mental Hygiene

Adler, Herman, M., M.D. Juvenile psychopathic institute and the work of the division of the criminologist. Ill. inst. quar., v. 9, no. 1, p. 1–13, March 31, 1918.

Allen, Charles L., M.D. Symptomatic psychoses. Med. and surg., v. 2, p. 350–56, March 1918.

American psychological association—Committee on reëducation research. Report of the above and of the similar Subcommittee of the Psychology committee of the National research council; by S. I. Franz. Psychol. bull., v. 14, p. 416–18, Dec. 1917.

Anderson, Victor V., M.D. Study of the physical conditions of 1,000 delinquents seen in court. Bost. med. and surg. j., v. 178, p. 803–07, June 13, 1918.

Associations of trustees, superintendents and matrons of county asylums for chronic insane of Wisconsin. Proceedings, v. 16, 1917. Mad.: 1918.

Austregesilo, A. Infectious psychoses, especially in tropical diseases. N. O. med. and surg. j., v. 70, p. 513–29, 1918.

Baker, Amos T., M.D. The mentally defective criminal. Bost. med. and surg. j., v. 179, p. 38–41, July 11, 1918.

Baldwin, Bird T., M.D. Psychology of juvenile delinquency. Ia. state conf. char. and corr. Proceedings, v. 19, p. 97–98, 1917.

Ball, Jau Don, M.D., and Thomas, Hayward G., M.D. Sociological, neurological, serological and psychiatrical study of a group of prostitutes. Amer. j. insan., v. 74, p. 647–66, April 1918. References.

Barkan, Hans, M.D. Some ocular defects in mentally retarded children. Calif. state med. j., v. 16, p. 183–84, 193, April 1918.

Bartlett, May. Plea for backward children. Train. school bull., v. 15, p. 50–54, June 1918.

Becker, W. F., M.D. The mental hygiene movement and psychiatry. Wis. med. j., v. 16, p. 379, March 1918.

Being a pauper idiot; how Kentucky has changed her century-old system of pensioning the feebleminded; by W. D. L. Survey, v. 40, p. 11–13, April 6, 1918.

Bevis, W. Marion, M.D. Florida's care for the insane. Fla. med. assoc. j., v. 4, p. 223, Feb. 1918.

Brainerd, Helen C. Red Cross work among mental patients. Mod. hosp., v. 10, p. 306–07, April 1918.

Braithwaite, J. V. C. Scientific aspect of psychic phenomena. Guy's hosp. gaz., Lond., v. 31, p. 412, 1917.

Bridgman, Olga. Experimental study of abnormal children, with special reference to the problems of dependency and delinquency. Univ. Calif. Pub. in psychol., v. 3, no. 1, 1918. 59 p.

Bridgman, Olga. Some special problems in abnormal adolescent psychology. Arch. ped., v. 35, p. 172, March 1918.

Brill, Abraham A., M.D., Adjustment of the Jew to the American environment. Mental hygiene, v. 2, p. 219–31, April 1918.

Brodsky, Emanuel S., M.D. Some educational problems of race hygiene. Med. rec., v. 93, p. 1028–33, June 15, 1918.

Burnett, S. Grover, M.D. Two cases of dual personality in inbred migraines. Chic. med. rec., v. 40, p. 27–33, 1918.

Burr, Charles W., M.D. State care of the feebleminded. Arch. ped., v. 35, p. 77, Feb. 1918.

Butler, Amos W. Colonies for public wards. Ind. bull. char. and corr., no. 112, p. 47–54, March 1918.

Byers, Joseph P. An institution's opportunity. Train. school bull., v. 15, p. 25–28, April 1918.

California—State board of charities and corrections. Surveys in mental deviation in prisons, public schools and orphanages in California. . . . Sacramento: 1918. 87 p.

Campbell, C. Macfie, M.D. A city school district and its subnormal children, with a discussion of some social problems involved and suggestions for constructive work. Mental hygiene, v. 2, p. 232–44, April 1918.

Canadian National Committee for Mental Hygiene. Editorial in Can. med. assoc. j. v., 8, p. 551–54, June, 1918.

Case, Irene, and Kate, Lewis. Environment as a factor in feeblemindedness; the

*This bibliography is uncritical and does not include articles or books of a purely technical or clinical value.

Nolly family. Amer. j. sociol., v. 23, p. 661–69, March 1918.

Causey, Frederick A., M.D. Welfare report of discharged cases. Ill. inst. quar., v. 9, no. 1, p. 58–60, March 31, 1918.

Chase, Robert H., M.D. The ungeared mind. Phil.: Davis, 1918. 351 p.

Clark, L. Pierce, M.D. The true epileptic. N. Y. med., j., v. 107, p. 817–24, May 4, 1918.

Clarke, C. K., M.D. Work of the psychiatric clinic of the Toronto general hospital. Tor. pub. health j., v. 9, p. 97–98, March 1918.

Cohn, Eugene, M.D. Open cottages at Kankakee state hospital. Mod. hosp., v. 10, p. 411–12, June 1918.

Coover, J. E. Experiments in psychical research at Leland Stanford Jr. University. Stanford Univ.: 1918. 641 p.

Copp, Owen, M.D. Barriers to the treatment of mental patients. Mental hygiene, v. 2, p. 254–64, April 1918.

Cornell, William B., M.D. Treatment of the feebleminded. N. Y. med. j., v. 107, p. 1067–68, June 8, 1918.

Creamer, D. S. "State program for the insane." Ohio state inst. j., v. 1, p. 61–65, June 1918.

The defective delinquent; papers read at the Annual conference of the Massachusetts society for mental hygiene, Boston, Jan. 1918. 32 p. Massachusetts society for mental hygiene, Publication no. 32.

Doll, Edgar A. Psychological measurements for thirteen pairs of feebleminded siblings. Train. school bull., v. 15, p. 45–47, May 1918.

Downey, June E. Constancy of the I. Q. J. delinquency, v. 3, p. 122–31, May 1918.

Drummond, Margaret. Dawn of mind; an introduction to child psychology. Lond.: Arnold, 1918. 179 p.

Emerick, E. J., M.D. Our duty to the feebleminded. O. state med. j., v. 14, p. 147, March 1918.

Epstein, Jacob J., M.D. The abnormal child. Med. times, v. 46, p. 66–69, 1918.

Eyman, Henry C., M.D. Reminiscences; thirty-four years with the insane. Ohio state inst. j., v. 1, p. 47–56, June 1918. Port.

Fairbanks, Gertrude M. Teaching the three R's to our children. Train. school bull., v. 15, p. 42–44, May 1918.

Faris, Ellsworth. Mental capacity of savages. Amer. j. sociol., v. 23, p. 603–19, March 1918.

Fernald, Walter E., M.D. Some of the limitations of the plan for segregation of the feebleminded. Ungraded, v. 3, p. 171–76, May 1918.

Fordyce, O. O., M.D. Changes in methods of treatment and management. Ohio state inst. j., v. 1, p. 38–44, June 1918.

Fox, Evelyn. The mental deficiency act and its administration. Eugen. rev., v. 10, p. 1–17, April 1918.

Freud, Sigmund. Reflections on war and death. N. Y.: Moffat, 1918. 72 p.

Freud, Sigmund. Totem and taboo. N. Y.: Moffat, 1918.

Glueck, Bernard, M.D. Concerning prisoners. Mental hygiene, v. 2, p. 177–218, April 1918.

Glueck, Bernard, M.D. Problem of the individual delinquent. Delinquent, v. 8, no. 2, p. 6–10, no. 3, p. 1–11, Feb. and March 1918.

Goddard, Henry H. Ohio bureau of juvenile research. Ohio state inst. j., v. 1, p. 5–9, June 1918. Port.

Gordon, Alfred, M.D. Morbid impulses; their diagnostic elements and medicolegal importance. N. Y. med. j., v. 107, p. 771–73, April 27, 1918.

Gordon, Alfred, M.D. Obsessive hallucinations and psychanalysis. J. abnor. psychol., v. 12, p. 423–30, Feb. 1918.

Gordon, Alfred, M.D. Obsessive hallucinations in a child and psychoanalysis. Med. and surg., v. 2, p. 344–49, March 1918.

Gordon, Alfred, M.D. The so-called lucid interval in manic-depressive psychoses; its medicolegal value. Amer. j. insan., v. 74, p. 667–78, April 1918.

Greene, M. K., M.D. Modern care and treatment of the insane in public institutions. Assoc. trustees, supts. and matrons of county asylums for chronic insane of Wisconsin. Proceedings, v. 16, p. 9–22, 1917.

Gregg, Donald, M.D. Diagnosis of acute psychotic conditions. Med. and surg., v. 2, p. 290–93, March 1918.

Griffin, George D. J., M.D. Psychology as a factor in surgery. Ill. med. j., v. 33, p. 161, March 1918.

Haberman, J. Victor, M.D. Probing the mind; second report. Med. rec., v. 93, p. 839–49, May 18, 1918. References.

Hall, Ethel. My work with delinquent girls. Ia. state conf. char. and corr. Proceedings, v. 19, p. 99–101, 1917.

Hallock, Frank M., M.D. Borderline psychoses. Neurol. bull., v. 1, p. 93–106, March 1918.

Hallock, Frank M., M.D. Social maladjustment; a compulsion neurosis in a young man turning the serious activities of his life into bizarre distortions. Neurol. bull., v. 1, p. 219–27, May 1918.

Harrington, Arthur H., M.D. The receiving unit of the state hospital at Howard, Rhode Island. Amer. j. insan., v. 94, p. 635–46, April 1918. Plans.

Hart, Hastings H. Trends in the treatment of the juvenile delinquent. Delinquent, v. 8, p. 10–12, Feb. 1918.

Hastings, George A. Registration of the feebleminded. N. Y.: State char. aid assoc., 1918.

Have we overestimated the alcohol factor in insanity? Scientific temperance j., v. 27, p. 91–96, June 1918.

Hickson, William J., M.D. Psychopathology and criminology. Med. and surg., v. 2, p. 245–65, March 1918.

Hill, David S. Educational research work in New Orleans. J. delinquency, v. 3, p. 132–36, May 1918. References.

Hill, Gershom H., M.D. An Iowa society for mental hygiene is certainly needed. Ia. state conf. char. and corr. Proceedings, v. 19, p. 51–55, 1917.

Hill, Gershom H., M.D. Is a society for mental hygiene needed in Iowa? Ia. bull. state inst., v. 20, p. 16–25, Jan. 1918.

Hill, Gershom H., M.D. Manic depressive insanity. Ia. state med. soc. j., v. 8, p. 138, April 1918.

Hill, Gershom H., M.D. A mental clinic. Ia. bull. state. inst., v. 20, p. 25–31, Jan. 1918.

Hincks, Clarence M., M.D. Mentally deficient children. Tor. pub. health j., v. 9, p. 102–05, March 1918.

Hoagland, Susan W. What are the institutions for children doing to prevent their mental defectives from becoming delinquent? J. delinquency, v. 3, p. 80–83, March 1918.

Howison, Norman L., M.D. Care and treatment of the chronic insane in county asylums. Assoc. trustees, supts. and matrons of county asylums for the chronic insane of Wisconsin. Proceedings, v. 16, p. 25–30, 1917.

Interrelation between mental defect and disorder. Editorial in Bost. med. and surg. j., v. 179, p. 54, July 11, 1918.

Ishida, Noboru, M.D. Non-restraint system in the insane wards of Nagasaki hospital. Mod. hosp., v. 10, p. 393–96, June 1918. Illus.

James, Walter B., M.D. The problem that mental disorders present to the medical profession and the profession's responsibility. Med. rec., v. 93, p. 353–56, March 2, 1918.

Jarrett, Mary C. Psychiatric social work. Mental hygiene, v. 2, p. 283–90, April 1918.

Jarrett, Mary C. Shell-shock analogues; neuroses in civil life having a sudden or critical origin. Med. and surg., v. 2, p. 206–80, March 1918.

Jelliffe, Smith Ely, M.D., and Brink, Louise. "I Mary MacLane"; a psychoanalytic review and appreciation. Interstate med. j., v. 25, p. 199–209, March 1918.

Jelliffe, Smith Ely, M.D. Technique of psychoanalysis. N. Y.: Nerv. and ment. dis. pub. co., 1918. 163 p. Monograph series no. 26.

Johnson, Oscar J. Effects of smoking on mental and motor efficiency. Psychol. clin., v. 12, p. 132–40, June 15, 1918. (To be concluded.)

Jones, Edith K. Emotional poise in war time: how the libraries can help the public. Reprint from Pub. libraries, Dec. 1917 and Jan. 1918.

Jones, Julian S. Legal aspect of the commitment and detention of the insane. Md. psychiat. quar., v. 7, p. 59–77, Jan. 1918.

Keister, Bittle C., M.D. Relation of internal secretions and faulty metabolism to mental perversions. Med. rec., v. 94, p. 4–7, July 6, 1918.

Keogh, Sir Alfred, ed. Neuroses. v. 2 of Medical and surgical therapy. N. Y.: Appleton, 1918. 933 p. illus.

Keys, Marjorie. Problem of the feebleminded. Tor. pub. health j., v. 9, p. 99–101, March 1918.

Kindred, John J., M.D. Eugenics; its relation to mental diseases. Med. rec., v. 93, p. 981–88, June 8, 1918.

Kleiser, Grenville. How to build mental power. N. Y.: Funk, 1918. 595 p.

Kroeber, Alfred L. Possibility of a social psychology. Amer. j. sociol., v. 23, p. 633–50, March 1918.

Kuhlmann, Fred. Syphilis in its relation to feeblemindedness. Minn. inst. quar., v. 17, p. 106–12, Feb. 1918.

Lacy, William I. Study of 100 retarded fourth grade pupils tested by the Binet scale. Psychol. clin., v. 12, p. 16–23, March 15, 1918.

Leahy, Sylvester R., M.D. Borderline psychiatry. Neurol. bull., v. 1, p. 212–18, May 1918. References.

Lemchen, Barnett, M.D. Normal and abnormal psychiatry. Med. rec., v. 93, p. 1123–24, June 29, 1918.

Lowrey, Lawson G., M.D. Analysis of the accuracy of early psychiatric diagnoses Med. and surg., v. 2, p. 281–89, March 1918.

Lowrey, Lawson G., M.D. Differential diagnosis in psychiatry; a comparison of symptoms in various disease states. Bost. med. and surg. j., v. 178, p. 703–08, May 23, 1918.

Lowrey, Lawson G., M.D. The psychopathic hospital ideal. Med. rec., v. 93, p. 503–04, March 23, 1918.

Luther, Jessie. Occupational treatment in nervous disorders. Mod. hosp., v. 11, p. 11–15, July 1918.

McCready, E. Bosworth, M.D. The mental health of our future citizens. Med. and surg., v. 2, p. 304–11, March 1918.

McCready, E. Bosworth, M.D. What can be done in childhood to promote sound mental health. Amer. med., new series, v. 13, p. 300–03, May 1918.

McIntire, Ruth. Child labor and juvenile delinquency. J. delinquency, v. 3, p. 95–114, May 1918.

Marshall, Mark, M.D. Treatment of chronic constipation with psychotherapy. Mich. state med. j., v. 17, p. 141, April 1918.

Mateer, Florence. The moron as a war problem. J. app. psychol., v. 1, p. 317–20, 1917.

Mead, George H. Psychology of punitive justice. Amer. j. sociol., v. 23, p. 577–602, March 1918.

Mead, Helen M. An experiment in after-care work. Ungraded, v. 3, p. 177–83, May 1918.

The mental hygiene movement in California. Calif. state med. j., v. 16, p. 161, April 1918.

Meyer, Adolf, M.D. Modern views and propositions on enforced treatment for mental diseases. Md. psychiat. quar., v. 7, p. 57–58, Jan. 1918.

Myerson, Abraham, M.D. The neurosis of the housewife. Med. and surg., v. 2, p. 294–303, March 1918.

Myerson, Abraham, M.D. Psychiatric family studies; second paper, dealing with the psychoses of brothers and sisters. Amer. j. insan., v. 74, p. 497–554, April 1918. References.

Ordahl, Louise E., and Ordahl, George. Study of delinquent and dependent girls. J. delinquency, v. 3, p. 41–73, March 1918.

Osnato, Michael, M.D. Critical review of the pathogenesis of dementia praecox in its relation to borderline psychoses. Neurol. bull., v. 1, p. 106–18, March 1918.

Otis, Flora E. Bibliography of practical helps for teachers of special classes. Train. school bull., v. 15, p. 60–61, June 1918.

Otis, Flora E. Literature on special classes. Train. school bull., v. 15, p. 48, May 1918.

Otis, Flora E. Work among the feeble-minded around Camp Dix. Train. school. bull., v. 15, p. 55–57, June 1918.

Parker, George M., M.D. Analytic view of the psychic factor in shock. N. Y. med. j., v. 108, p. 12–17, 58–61, July 6–13, 1918.

Parker, Sarah W. Orthogenic cases . . . Obadiah, a child with a numerical obsession. Psychol. clin., v. 12, p. 105–31, June 15, 1918.

Paschal, Franklin C. Report on the standardization of the Witmer cylinder test. Psychol. clin., v. 12, p. 54–59, April 15, 1918.

Phelps, R. M., M.D. Syphilis in its relation to insanity. Minn. inst. quar., v. 17, p. 102–05, Feb. 1918.

Pintner, Rudolf, and Reamer, Jeannette. Mental ability and future success of delinquent girls. J. delinquency, v. 3, p. 74–79, March 1918.

Pintner, Rudolf. The mental survey. N. Y.: Appleton, 1918. 116 p.

Pintner, Rudolf, and Toops, H. A. Mental tests of unemployed men. J. app. psychol., v. 1, p. 325–41, 1917.

Pollock, Horatio M. Economic loss to the state of New York on account of syphilitic mental diseases during the fiscal year ending June 30, 1917. Mental hygiene, v. 2, p. 277–82, April 1918. Also in N. Y. state hosp. quar., v. 3, p. 241–46, May 1918.

Poull, Louise E. Study of 150 feeble-minded delinquents. Ungraded, v. 3, p. 197–202, June 1918. References.

Psychic disturbances of locomotor ataxia. Editorial in Med. rec., v. 94, p. 69–70, July 13, 1918.

The Psychopathic hospital of the laboratory of social hygiene, Bedford Hills, N. Y. J. sociol. med., v. 19, p. 85–100, April 1918.

Read, Charles F., M.D. Mental depression. Ill. med. j., v. 33, p. 253, May 1918.

Rest cure through the infinity of time. Editorial in N. Y. med., j., v. 107, p. 751–52, April 20, 1918. A statement of the basis of psychotherapy from the point of view of ethnology.

Ross, Edward A. Social decadence. Amer. j. sociol., v. 23, p. 620–32, March 1918.

Ruger, Georgie J., comp. Psychological tests; a bibliography. N. Y.: Bur. educ. experiments, 1918. 111 p.

Russel, Evelyn M. Origin, organization and scope of the Canadian National Committee for Mental Hygiene. Can. med. assoc. j., v. 8, p. 538–46, June 1918.

Russell, William L., M.D. Returned disabled soldiers of Canada. Mental hygiene, v. 2, p. 245–53, April 1918.

Ryther, Margherita, and Ordway, Mabel, M.D. Economic efficiency of epileptic patients. J. nerv. and ment. dis., v. 47, p. 321–42, May 1918.

Sandy, William C., M.D. Standardization of hospitals for the insane. Mod. hosp., v. 11, p. 6–11, July 1918.

Sandy, William C., M.D. Syphilis in relation to mental disease. N. Y. med. j., v. 107, p. 734–36, April 20, 1918.

Schlapp, Max G., M.D. Theoretical considerations of mental deficiency. Med. rec., v. 93, p. 441–46, March 16, 1918.

Scope of mental hygiene. Editorial in Bost. med. and surg. j., v. 178, p. 404–05, Mar. 21, 1918.

Scripture, Mrs. May Kirk. Stuttering and stammering (lisping). Laryngoscope, v. 28, p. 156, March 1918.

Sexton, F. H. Vocational rehabilitation of soldiers suffering from nervous diseases. Mental hygiene, v. 2, p. 265–76, April 1918.

Sing Sing prison—Psychiatric clinic. First annual report. N. Y.: Natl. comm. ment. hygiene, 1917. 67 p.

Slingerland, W. H. Education and the training of dependent children. Relig. educ., v. 12, p. 408–14, Dec. 1917.

Smith, Joseph, M.D. Mental disease. Med. rec., v. 93, p. 722–24, April 27, 1918.

Smith, R. Percy, M. D. Aphasia in relation to mental disease. J. ment. sci., Lond., v. 64, p. 1–18, Jan. 1918.

Smith, W. G. Psychology and public health. Tor. pub. health j., v. 9, p. 106–08, March 1918.

Solomon, Meyer, M.D. How far can the mind really influence the body? Med. and surg., v. 21, p. 357–64, March 1918. References.

Some underlying principles with plan for special class programs. Ungraded, v. 3, p. 191–93, May 1918.

Sommer, Henry, J., M.D., and Saha, Pramathanath, M.D. Proposed basis for a dietary for hospitals for the insane to meet war conditions. Hollidaysburg, Pa.: Blair co. hosp., 1918. 57 p.

Spaulding, Edith R., M.D. Problem of venereal disease in its relation to penal institutions. Med. rec., v. 93, p. 714–19, April 27, 1918. References.

Spaulding, Edith R., M.D. Value of mental, physical and social studies of delinquent women. J. crim. law and criminol., v. 9, p. 80–97, May 1918.

Specht, Louise F. Socializing the work of the ungraded classes in Public school 64, Manhattan. Ungraded, v. 3, p. 212–13, June 1918.

Stearns, A. Warren, M.D. Value of out-patient work among the insane. Amer. j. insan., v. 74, p. 595–602, April 1918.

Stedman, Henry R., M.D. Recent progress in psychiatry; the teaching of psychiatry; military psychiatry. Bost. med. and surg. j., v. 178, p. 638–43, May 9, 1918. References.

Stern, Adolph, M.D. On the nature of the transference in psychanalysis. N. Y. med. j., v. 107, p. 398–402, March 2, 1918.

Stern, Adolph, M.D. Parent and child. Amer. med., new series, v. 13, p. 145–51, March 1918.

Stern, Adolph, M.D Some manifestations of the parent complex. Med. rec., v. 93, p. 664–68, April 20, 1918.

Stern, Adolph, M.D. The unconscious. N. Y. med. j., v. 107, p. 869–72, May 11, 1918.

Stewart, Albert C., M.D. Character of a violent ward. N. W. med., v. 17, p. 103, April 1918.

Stone, Esther H., M.D. Plea for early commitment to correctional institutions of delinquent children, and an indorsement of industrial and vocational training in these institutions. Ill. inst. quar., v. 9, no. 1, p. 60–66, March 31, 1918.

Swift, Walter B., M.D. Speech defects in school children and how to treat them. Bost.: Houghton, 1918. 128 p.

Survey shows need of bureau of juvenile research. Ohio state inst. j., v. 1, p. 11–21, June 1918. Illus.

Sylvester, R. H. Work with backward children in the public schools of Iowa. Ungraded, v. 3, p. 140–43, March 1918.

Taft, Jessie. Limitations of the psychiatrist. Med. and surg., v. 2, p. 365–69, March 1918.

Tannenbaum, Samuel A., M.D. Some current misconceptions of psychoanalysis. J. abnor. psychol., v. 12, p. 390–422, Feb. 1918.

Tannenbaum, Samuel A., M.D. The unconscious in our daily life. Amer. j. urol. and sexol., v. 14, p. 1–22, Jan. 1918. (To be continued.)

Taylor, Edward W., M.D. Suggestions regarding a modified psychoanalysis; hysterical blindness. J. abnor. psychol., v. 12, p. 361–74, Feb. 1918.

Taylor, J. Danforth, M.D. The physician and psychology. Bost. med. and surg. j., v. 178, p. 730–31, May 30, 1918.

Terman, Lewis M. Errors in scoring Binet tests. Psychol. clin., v. 12, p. 33–39, April 15, 1918.

Terman, Lewis M., and Wagner, Dorothy. Intelligence quotients of 68 children in a California orphanage. J. delinquency, v. 3, p. 115–21, May 1918.

Thomas, P. E. New method of caring for prisoners and defectives. Ohio state inst. j., v. 1, p. 32–36, June 1918.

Toomey, Joseph H., M.D. Sex in life; the relation of sex education to mental hygiene. N. Y. med. j., v. 107, p. 688–92, p. 739–42, April 13 and 20, 1918.

Treadway, Walter L., M.D. Some observations on the personality of feeble-minded children in the general population. U. S. pub. health rept., v. 33, p. 760–68, May 17, 1918.

Vocational therapy in mental hospitals. Mod. hosp., v. 11, p. 45–46, July 1918. Illus.

Walker, William K., M.D. Hyperthyroidism and mental disorders. N. Y. med. j., v. 107, p.391–94, March 2, 1918.

Wallin, J. E. Wallace. Analysis of Binet-Simon records. School and soc., v. 7, p. 387–90, March 30, 1918.

Wallin, J. E. Wallace. Peg formboards. Psychol. clin., v. 12, p. 40–53, April 15, 1918.

Wallin, J. E. Wallace. Preliminary impressions of the Stanford revision of the Binet-Simon scale. Psychol. clin., v. 12, p. 1–15, March 15, 1918.

Wechsler, Israel S., M.D. Rôle of the emotions in the genesis of insanities, and insanity from the standpoint of evolution. J. abnor. psychol., v. 12, p. 375–89, Feb. 1918.

Whitehouse, Herbert. Diagnosis of degeneracy from conditions revealed by a field study of Green Lake county, Wisconsin. J. crim. law and criminol., v. 9, p. 46–79, May 1918. References.

Whitney, Roy L., M.D Study of cases of manic-depressive psychosis arising after

the age of forty. Amer. j. insan., v. 74, p. 587–93, April 1918.

Williams, J. Harold. Some feeble-minded charity cases in California. Train. school. bull., v. 15, p. 36–42, May 1918.

Williams, Tom A., M.D. Suicide and civilization. J. sociologic med., v. 19, p. 4–18, Feb. 1918.

Wills, T. H. Hamilton branch of the Provincial association for the care of the feebleminded. Tor. pub. health j., v. 9, p. 112–15, March 1918.

Winner, Peter S., M.D. State hospital medical service systematized. Ill. inst. quar., v. 9, no. 1, p. 13–19, March 31, 1918.

DIRECTORY OF SOCIETIES AND COMMITTEES FOR MENTAL HYGIENE

(Listed in the order of their origin)

The Connecticut Society for Mental Hygiene
(Organized, May, 1908)
39 Church Street, New Haven, Conn.
Miss V. M. Macdonald, Secretary
Miss Inez Newman, Associate Secretary

The National Committee for Mental Hygiene, Inc.
(Organized, February, 1909)
50 Union Square, New York City
Dr. Thomas W. Salmon, Medical Director
Dr. Frankwood E. Williams, Associate Medical Director
Clifford W. Beers, Secretary

The Illinois Society for Mental Hygiene
(Organized, July, 1909)
824 South Halsted Street, Chicago, Ill.
Miss Elnora E. Thomson, Executive Secretary
Mrs. Eleanor C. Slagle, Director of Occupations

Committee on Mental Hygiene of The New York State Charities Aid Association
(Organized, May, 1910; an outgrowth of an After-care Committee, organized in 1906)
105 East 22nd Street, New York City
George A. Hastings, Executive Secretary
Miss Jessie Taft, Social Service Director

The Massachusetts Society for Mental Hygiene
(Organized, January, 1913)
1132 Kimball Building, 18 Tremont Street, Boston, Mass.
Dr. Charles E. Thompson, Secretary

The Mental Hygiene Society of Maryland
(Organized, March, 1913; an outgrowth of an After-care Committee, organized in 1911)
401 Garrett Building, Baltimore, Md.
Dr. Charles B. Thompson, Executive Secretary

The Committee on Mental Hygiene of the Public Charities Association of Pennsylvania
(Organized, March, 1913)
Empire Building, Philadelphia, Pa.
Kenneth L. M. Pray, Acting Secretary

The North Carolina Society for Mental Hygiene
(Organized, December, 1913)
Dr. Albert Anderson, Secretary, Raleigh, N. C.

The Dayton Mental Hygiene Committee
(Organized, March, 1914)
Address: Mrs. J. Franz Dolina, or Mr. A. G. Knebel, Dayton, Ohio.

The Society for Mental Hygiene of the District of Columbia
(Organized, April, 1915)
Dr. D. Percy Hickling, Secretary
1305 Rhode Island Avenue, Washington, D. C.

The Alabama Society for Mental Hygiene
(Organized, April, 1915)
Dr. W. D. Partlow, Secretary, Tuscaloosa, Ala.

The Louisiana Society for Mental Hygiene
(Organized, May, 1915)
Dr. Maud Loeber, Secretary
1729 Marengo Street, New Orleans, La.

The California Society for Mental Hygiene
(Organized, June, 1915)
Miss Julia George, Secretary
638 Phelan Building, San Francisco, Cal.

The Rhode Island Society for Mental Hygiene
(Organized, March, 1916)
Dr. Frederick J. Farnell, Secretary
335 Angell Street, Providence, R. I.

The Ohio Society for Mental Hygiene
(Organized, May, 1916)
Dr. Thomas H. Haines, Secretary
Ninth and Oak Streets, Columbus, Ohio.

The Tennessee Society for Mental Hygiene
(Organized, May, 1916)
C. C. Menzler, Secretary
Nashville, Tenn.

The Missouri Society for Mental Hygiene
(Organized, May, 1916)
Dr. Francis M. Barnes, Jr., Secretary
Humbolt Building, St. Louis, Mo.

The Indiana Society for Mental Hygiene
(Organized, October, 1916)
Frank D. Loomis, Secretary
88 Baldwin Block, Indianapolis

The Iowa Society for Mental Hygiene
(Organized, March, 1917)
Dr. Gershom H. Hill
Des Moines, Iowa

The Virginia Society for Mental Hygiene
(Organized, March, 1917)
Dr. William F. Drewry
Petersburg, Va.